Namibia Capacity Building for Country Owned HIV/AIDS Services

FY 2012 Quarter 4 (July - September 2012)
and
Annual Program Progress Report
(October 2011 – September 2012)

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NAMIBIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMS	Anglican Medical Services
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BMI	Body Mass Index
C&T	Care and Treatment
CAA	Catholic AIDS Action
CBO	Community-Based Organization
CCN	Council of Churches in Namibia
CDC	Centers for Disease Control and Prevention
CHS	Catholic Health Services
CM	Community Mobilizers
CTP	Cotrimoxazole Prophylaxis
DAPP	Development AID from People to People
ELCAP	Evangelical Lutheran Church AIDS Program
ELISA	Enzyme-Linked Immunosorbent Assay
EMIS	Education Management Information System
EmOC	Emergency Obstetric Care
EMTCT	Elimination of Mother-to-Child Transmission of HIV
ePMS	Electronic Patient Management System (FileMaker Data System)
EQA	External Quality Assurance
FBO	Faith-Based Organization
FBH	Faith-Based Hospital
FP	Family Planning
GRN	Government Republic Namibia
HCS	HIV Clinicians' Society
HIV	Human Immunodeficiency Virus
HRMIS	Human Resource Management Information Systems (MoHSS Sub Division)
HRIMS	Human Resource Information Management System (Office of the Prime Minister)
HRIS	Human Resources Information System
HCT	HIV Counseling and Testing
IMAI	Integrated Management of Adolescent and Adult Illness
IPT	INH Preventive Therapy
IT	Information Technology
LL/CL	LifeLine/ChildLine
LMS	Lutheran Medical Services
MARP	Most-At-Risk Population
MC	Male Circumcision
MCP	Multiple Concurrent Partnership
M&E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health
MoHSS	Ministry of Health and Social Services
MOU	Memorandum of Understanding
NDF	National Defense Forces
NFS	National Strategic Framework
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NRCS	Namibia Red Cross Society
NS	New Start
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PI	Performance Improvement
PITC	Provider-Initiated Testing and Counseling
PLHIV	Person Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PO	HIV Prevention Officer
PwP	Prevention with Positives
QA	Quality Assurance
RMT	Regional Management Team
RT	Rapid Testing

RTK	Rapid Test Kit	TWG	Technical Working Group
SBCC	Social Behavior Change Communications	USAID	United States Agency for International Development
SCMS	Supply Chain Management Systems	VCT	(HIV) Voluntary Counseling and Testing
STI	Sexually Transmitted Infection		
TA	Technical Assistance	VMMC	Voluntary Medical Male Circumcision
TB	Tuberculosis		

Program Results (required)

See Excel spreadsheet ("INTRAHEALTH FY12 APR Results (Oct.11-Sep.12) and complete worksheet on table of program results.

2012 Program Summary:

In FY2012 the project assumed its name "Capacity Building for Country Owned HIV/AIDS Services," reflecting its focus on the Global Health Initiative principles of local ownership, sustainability, evidenced-based approaches, innovation and services integration. IntraHealth incorporated these principles into all of its technical assistance provided and the activities implemented by the project partners: Anglican Medical Services (AMS), Catholic Health Services (CHS), Lutheran Medical Services (LMS) and the HIV Clinicians Society (HCS). The project achieved significant impact during FY2012 and this report highlights the achievements for the fourth quarter and for the entire year of implementation.

Enhanced clinical HIV service delivery within Namibia: Important components of the health care continuum have been thoughtfully improved by the technical assistance (TA) provided for the MoHSS and the implementing health facilities. Intrahealth has been a technical leader in supporting health workers in Namibia and has partnered gracefully with the MoHSS and numerous health facilities to directly improve the services received by the people of Namibia. The rich and diverse technical assistance provided has included south-south exchanges and the introduction of cutting edge approaches. These continuing successes highlight the potential of these successful working relationships, drawing on the strengths of the guiding Ministry, implementing health facilities, a technical international NGO and the support of USAID. During 2012, this dynamic partnership realized many successes to enhance the clinical service delivery within Namibia:

- To improved services received by patients, The MoHSS developed and piloted a bi-directional referral system in four regions: , Khomas, Oshikoto, Oshana and Kavango. At the end of the pilot, an assessment was conducted and a final report will be shared. The bi-directional referral system will be extended to other regions and other service delivery areas next fiscal year.
- To alleviate space challenges and improve quality of services, seven prefabricated structures were procured for Onandjokwe, Odibo, Andara, Nyangana and Rehoboth. This new space will allow programs such as the kitchen corner and provision of VMMC in Onandjokwe to be revived and improved. The much anticipated mobile HCT units were delivered and these vehicles will be handed over to the MoHSS during Quarter 1 FY13. These vehicles will directly increase the provision of mobile HCT services and other primary health care services in hard to reach areas.
- To improve access and quality of maternal and neonatal services, IntraHealth provided focused technical assistance for:
    - The Kavango Regional Management Team conducted an EmOC/ LSS training. Managers, midwives and doctors from all the 4 districts of Kavango were trained over a period of 4 weeks.
    - The MoHSS PHC, RMTs and Trainers developed a strong follow up plan which incorporates performance improvement approaches to ensure site specific interventions are developed for specific gaps to address quality of care issues.

- MoHSS to conduct a maternal and neonatal mortality study in 5 regions namely Erongo, Khomas, Omaheke, Hardap and Karas. The protocol and tools have been finalized and submitted to MoHSS for approval.

- To increase the operational research skills in Namibia, IntraHealth conducted an applied operational research workshop with support from UNAM and MoHSS with participants from the MoHSS and faith based institutions. All attendees developed a practical OR protocol that can be conducted in their institution.

Interventions targeting health system strengthening with a specific focus on improving human resources for health

iHRIS The new human resource information system (iHRIS) has been launched and is being used in the MoHSS and the Office of Prime Minister (OPM) The migration of the data from the former HRIMS to the new HCMS has been completed. The OPM is supported by Intrahealth to fully operationalize the HCMS through documenting how HCMS will be used to make decisions about Human Resources through standardized data lists and producing reports required by MoHSS. Since the HCMS data only included human resources information from the MoHSS, IntraHealth is supporting adaptation of the iHRIS Manage into all faith based hospitals. This customization of the iHRIS Manage started at LMS bystrengthening their IT infrastructure through procuring computers, printers and implementing a Local Area Network. Key data elements from faith based facilities will be shared with the MoHSS so they can compile a comprehensive list of the staff that they are supporting financially. These capacity building efforts will be supported by the training of four information system interns from Polytechnic University.

OCAs The overall management capacity of the implementing partners has improved throughout the year. IntraHealth has provide relevant technical assistance to build the capacity of partners programmatically and operationally through training, development of tools, on-the-job skills updates, refresher clinical skills training, and policy updates. We have focused on ensuring that proper management systems, including financial management and reporting systems, are in place for compliance with USG rules, regulations, and procurement. The program conducted Organizational Capacity Assessments (OCAs) to identify organizational strengths, weaknesses and gaps which necessitate further assistance. Resulting from the OCAs, FBOs developed strategic plans to map future activities for the next three to five years. The OCAs results guided the integration of the vertical "standalone" HIV programs into the larger health facility, a major accomplishment implemented by LMS.

WISN The MoHSS is currently undergoing a restructuring effort to revise the staffing norms to meet the actual workload requirements. Kavango Region, one of 13 regions in the country, requested technical assistance from IntraHealth to estimate their staffing requirements using workload estimates. The WHO Workload Indicator of Staffing Needs (WISN) methodology was selected to determine the workload based staffing requirements. The staffing requirement for nurses, doctors, pharmacist and pharmacy assistants in intermediate hospitals, district hospitals, health centers, clinics and the Multi regional medical depot were determined. The Kavango WISN results and proposed new norms were presented to the Kavango regional management team as well as to the MoHSS restructuring committee. Dr. Norbert Foster the Deputy Permanent Secretary of the MoHSS and also the Chairman of the restructuring committee then requested that WISN should also be conducted for the entire health sector. In addition, Dr. Foster requested Intrahealth to determine the workload estimates for the two main teaching hospitals in Namibia: Windhoek Central Hospital and Katutura Intermediate Hospital.

Program-Area Narratives for October 2011 – September 2012

2.1 Program Area 1: Prevention of Mother-to-Child Transmission of HIV (PMTCT) and Maternal, Newborn and Child Health (MNCH)

The project's prevention of mother-to-child transmission (PMTCT) component focuses on reducing the incidence of vertical transmission of HIV by increasing the proportion of HIV-positive women and their exposed babies who are provided with antiretroviral (ARV) prophylaxis. Our technical assistance in PMTCT is targeted towards antenatal clinics and labor and delivery wards at six faith-based facilities (five hospitals and one health center). Consistent with the MoHSS agenda on the elimination of mother to child transmission (eMTCT), IntraHealth supports the implementation of the four-pronged approach to PMTCT with an enhanced focus on prong 1, primary prevention of HIV infection among women of reproductive age, and prong 2, prevention of unintended pregnancies through provision of family planning (FP). We also support prongs 3 and 4, preventing HIV transmission from women living with HIV to their infants and providing appropriate treatment, care and support to mothers living with HIV, their children and families. In addition to our PMTCT work, during FY12, IntraHealth began supporting six (6) faith-based hospitals to improve emergency obstetric care (EmOC) and reduced maternal mortality.

By the end of the reporting period, IntraHealth was supporting 56 outlets in and around mission facilities for PMTCT services. These sites include the six faith-based facilities cited above plus 50 facilities in surrounding communities that fall under our partners' management, though not all are faith-based. This level of coverage means that only seven facilities remain within the catchment area of IntraHealth-supported hospitals that are not yet offering PMTCT. In FY13 IntraHealth will continue supporting its partners to scale up to 100% PMTCT coverage in line with the national plan for elimination of mother to child transmission (eMTCT).

Accomplishments & Successes

Maternal, Neonatal and Child Health:

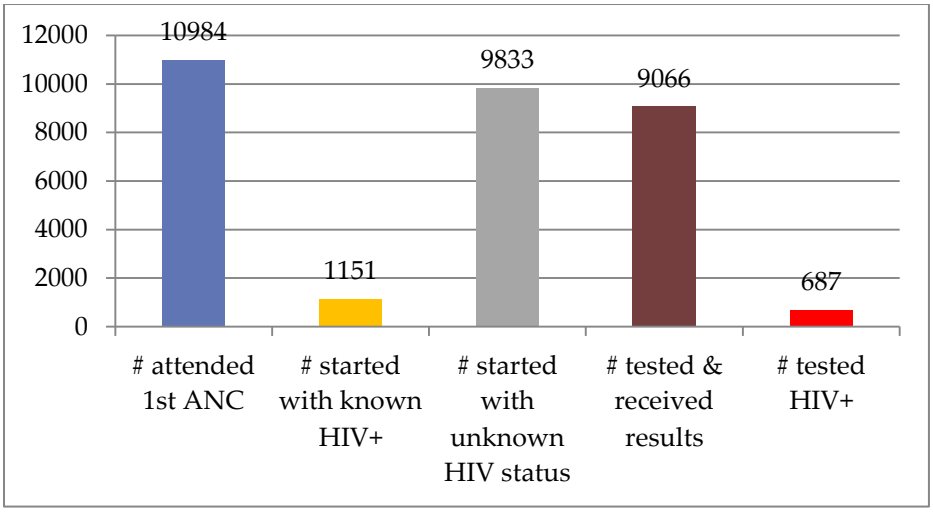
- IntraHealth conducted a site visit and identified essential equipment required including cardio-tocography (CTG), CPAP machines, ultrasound scans, autoclaves, hemoglobin meters, infant warmer systems, vacuum extractors, infant oxymeters and fetal dopplex. All of these EmOC equipment's have been procured, except CPAP and infant warmers, and will be handed over to the respective partners.
- Near-miss approach was introduced in Andara, Nyangana and Oshikuku maternal & peri/neonatal death review committees to improve the quality of care aimed to reduce maternal and neonatal mortality. To date, Andara has been utilizing this approach to review maternal complications. IntraHealth will strengthen this approach in the Quarter 1 FY13 including documenting the cases reviewed.
- Performance improvement approach was introduced to the maternal & peri/neonatal death review committees to identify gaps to quality MNCH services.
- PMTCT/MNCH Officer attended a three weeks Emergency Obstetric and Neonatal Care and Life Saving Skills (EmONC/LSS) training offered by the American College of Nurse Midwives with support from WHO.
- IntraHealth supported comprehensive four week EmONC/LSS training for Kavango region. The training which includes one week training for managers, another week for focused antenatal care (FANC) and two weeks of EmONC/LSS,. Discussions are underway for EmONC/LSS training for the Erongo region.
- The protocol and tools have been developed for the maternal and neonatal mortality study in Erongo, Khomas, Omaheke, Hardap and Karas regions. The protocol will be submitted to the MoHSS Research and Ethics committee and the IntraHealth IRB towards the end of October 2012. To support this process, IntraHealth's Safe Motherhood and Newborn Advisor provided technical assistance for protocol development. IntraHealth is engaging the Multi-disciplinary Research Council (MRC) at University of Namibia to provide support activities such as data management, analysis and focus group discussions.
- IntraHealth provided technical assistance to draft a proposal for a peri-natal mortality study in Oshikuku district. The Oshikuku team will be providing comments shorty.
- At the request of the Mission, IntraHealth provided guidance to the MoHSS's Primary Healthcare (PHC) Director on the minimum requirements and principles for maternity waiting homes.

Antenatal Care: During quarter four, a total of 2,874 women attended a first ANC visit, of which 307 (11%) started ANC with known HIV positive status, and 2,567 (89%) with unknown status. Of those mothers with unknown HIV status, 2,342 (91%) were newly tested and received their HIV test results. The total number of ANC women with known HIV status is 2,649. There are about 10% ANC clients with unknown HIV status, thus not tested or not received their HIV test results and this could be due to the following reasons, some clinics have no RT services and rather use ELISA that takes a bit of time, and other reason is not all clients with unknown status accepted the test.

During FY12, a total of 10,984 women attended a first ANC visit, of which 1151 (10%) started ANC with known HIV positive status, and 9,833 (90%) with unknown status. Of those mothers with unknown HIV

status, 9,066 (90%) were newly tested and received their results. The total number of pregnant women with known HIV status is 10,217(figure 1)

Figure 1.Women attending ANC, tested for HIV, and test results October 2011-September 2012



Of the total pregnant women counseled and tested in the fourth quarter 152 (6%) tested HIV positive, bringing the total for FY12 to 687 (8%). These numbers include women attending ANC at peripheral clinics within mission-supported districts.

The FY12 target of 6,640 pregnant women who know their HIV status through ANC, thus those known HIV positive at entry and those tested during their first visit, is exceeded by 53%. As part of the PMTCT couple counseling program, among the 2,342 women counseled and tested, 111 (5%) were tested along with their partners during the fourth quarter of FY12. Of those partners tested, 6 (5%) tested positive and additional 78 are known HIV positive.

During FY12, the total number of women counseled and tested is 9,066 of which 436 (5%) were tested along with male partners. Of the 436 men tested during the reporting period 42 (10%) tested HIV positive and additional 206 are known with HIV positive status. All women testing HIV positive were referred for enrollment into HIV care and assessment for treatment. Those women testing HIV negative before the third trimester were counseled on prevention and encouraged to take a repeat test during the last trimester. Of the 45 women retested during the fourth quarter none tested positive. During FY12, 261 women were retested and 8 (3%) tested positive.

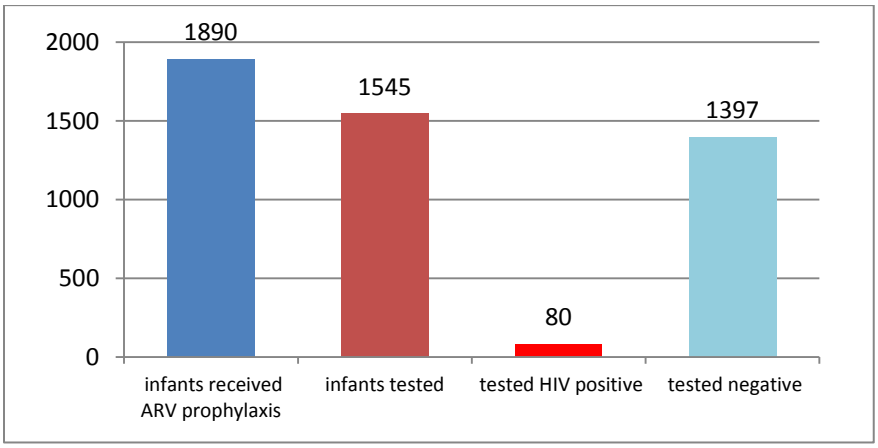
Labor & Delivery: during the fourth quarter, a total 2,862 women delivered in IntraHealth supported health facilities with 2,789 (97%) knowing their HIV status. During this period, a total of 491 HIV positive women delivered in these facilities, of which 302 (62%) received ART and 175 (36%) received ARV prophylaxis. A total of 477 newborns received ARV prophylaxis during the fourth quarter. Most (99%) HIV positive women chose exclusive breastfeeding as their preferred infant feeding option.

During FY12, a total of 10,746 women delivered at IntraHealth supported facilities, of which 10,528 (98%) knew their HIV status. During this period, a total of 1,856 HIV positive women delivered in these facilities, of which 1,160 (63%) received ART and 541 (29%) received ARV prophylaxis. A total of 1890

infants received ARV prophylaxis during this time. Most (99%) HIV positive women chose exclusive breastfeeding as their preferred infant feeding option.

During FY12, a total of 1890 HIV exposed infants received ARV prophylaxis, and of the 1545 of those who were tested, 80 (4%) tested HIV positive. (Figure 2)

Figure 2: Infants tested for HIV and those who received ARV prophylaxis in FY 12



Postnatal Care: A total of 445 exposed infants were tested with DNA polymerase chain reaction (PCR) during the fourth quarter, of which 34 (8%) tested HIV positive. This figures increased from 5.5% the same period last year to 8% this quarter. This adverse trend is noted and will be followed up to identify the possible causes of increase HIV positive rate for infants, especially at Nyangana which has the highest sero conversion of 9% compared to other sites. A total of 337 HIV exposed babies were enrolled for follow-up during this period, and 364 of them were initiated on cotrimoxazole prophylaxis. The FY12 figures show that 1545 exposed infants were tested, of which 80 (5%) tested HIV positive. Of the 1545 babies tested during the year, 913 (59%) were tested within 2 months of birth.

HIV & FP Integration: during the fourth quarter, a total of 331 HIV positive women were enrolled in postnatal care and 279 (84%) women were referred for family planning. During this reporting period 287(102%) women were counseled, and accepted family planning. The reason for FP referrals exceeding 100% is due to the women who were referred last quarter and enrolled this quarter.

During FY12, 1238 HIV positive women enrolled in postnatal care services. Of the 1089 (88%) referred women, 933 (86%) were counseled and enrolled for family planning.

Additional Accomplishments and Highlights

- All supported faith-based district hospitals are implementing repeat testing at 36 weeks for pregnant women who initially tested negative in earlier trimesters.
- PMTCT registers and data collection tools are updated, consistent with the current national guidelines that were distributed to all facilities.

- Conducted a two day orientation on the new PMTCT, ANC and labor data collection tools in Onandjokwe.
- Three clinics in Oshikuku district are certified as RT sites
- Odibo, Andara and Nyangana district hospitals are offering FP services at ART clinic; IntraHealth will support all other FBHs to replicate this best practice.
- Prefabs procured for Odibo will support the integration of HIV DNA PCR into PHC clinic.
- The majority of mothers (98%) delivering in the faith-based hospitals came to deliver with known HIV status. Almost all mothers coming to deliver with an unknown status were tested during labor or soon after delivery.
- Two clinics in Oshikuku district are renovated which will facilitate RT rollout in Oshikuku district.
- Rehoboth Hospital has integrated all PMTCT services to Rehoboth health center
- Nurses at Odibo are rotating to the ARV clinic to support transition and ensure continuum quality of care to HIV+ clients

Challenges, Constraints & Plans to overcome them

- Mortality data for EmOC are not made to IntraHealth. IntraHealth will continue to consult with the MoHSS on the outcome of the request to avail the information on maternal mortality sent during the third quarter.
- PMTCT/EID training is delayed due to competing priorities within partner organization and IH will support partner staff to be trained during FY13.
- Low coverage for DNA/PCR due to lack of EID training among staff specifically in CHS facilities. IH will support EID on these training and ensure partner staff are trained
- Passive follow up of HIV exposed babies, the national baby-mother follow system is being piloted and IH will support the rollout once this system is finalized
- Staff resignations due to transition are affecting service delivery in some facilities.
- IH will collaborate with partners and MoHSS to ensure continuum of service during transition period and beyond.

Plans for Quarter 1 FY13

- Continue to participate in the PMTCT Technical Working Group (TWG) and Maternal and Child Health (MCH) Committee.
- Continue to collaborate with the MoHSS for the implementation of MNCH program in all faith-based facilities.
- Conduct a baseline review and assessment in maternal and neonatal care and identify areas for strengthening. Implement Performance Improvement Approach to identify areas for improvement.
- Collaborate with Kavango regional team to develop a follow up plan for monitoring EmONC activities and to ensure trained staffs are implementing the skills learned during the training.
- Collaborate with the national ToT`s to develop job aids for the management of maternal, neonatal and labor complications.

- Support EmONC/LSS training for Erongo region.
- Support PMTCT/EID training for partner staff.
- Support the rollout of mother-baby follow up system.
- Support the training of medical doctors in anesthesia for Andara and Nyangana .
- Support in-service training of midwives in all obstetric departments in all FBH`s on basic lifesaving skills (LSS).
- IntraHealth will support partner organizations and hospital management teams in the integration of FP into other services.
- Implement performance improvement approach in all Maternal, Peri- and Neonatal Death Review Committees to identify gaps, develop and implement interventions in addressing those gaps.
- Submission of maternal and neonatal mortality study proposal to MoHSS Research and Ethics Committee and commence data collection once approval is granted.
- Support and provide TA for the zonal maternal, peri-natal and neonatal mortality meeting for Oshana, Ohangwena, Oshikoto and Omusati regions.

2.2 Program Area 2: Voluntary Medical Male Circumcision

IntraHealth works to improve access to high quality HIV prevention services, and strives to make men aware of, and have access to, voluntary medical male circumcision (VMMC) services as a component of comprehensive HIV prevention. The minimum package for voluntary medical male circumcision (VMMC) package has been implemented including screening and management of sexually transmitted infections (STIs), behavior change counseling (risk reduction), provider-initiated counseling and testing (PICT) and condom promotion and distribution. Currently, all six IntraHealth-supported sites are offering VMMC. In Odibo, on site orientation was conducted to ensure that MC standards are adhered too. One doctor was oriented during the exercise.

IntraHealth is an active member of the Namibian VMMC task force, and will continue to contribute to the development and implementation of national VMMC strategy and supporting policies and technical recommendations. In addition, IntraHealth is actively involved in advocacy and communication efforts to ensure safe and voluntary male circumcision nationwide.

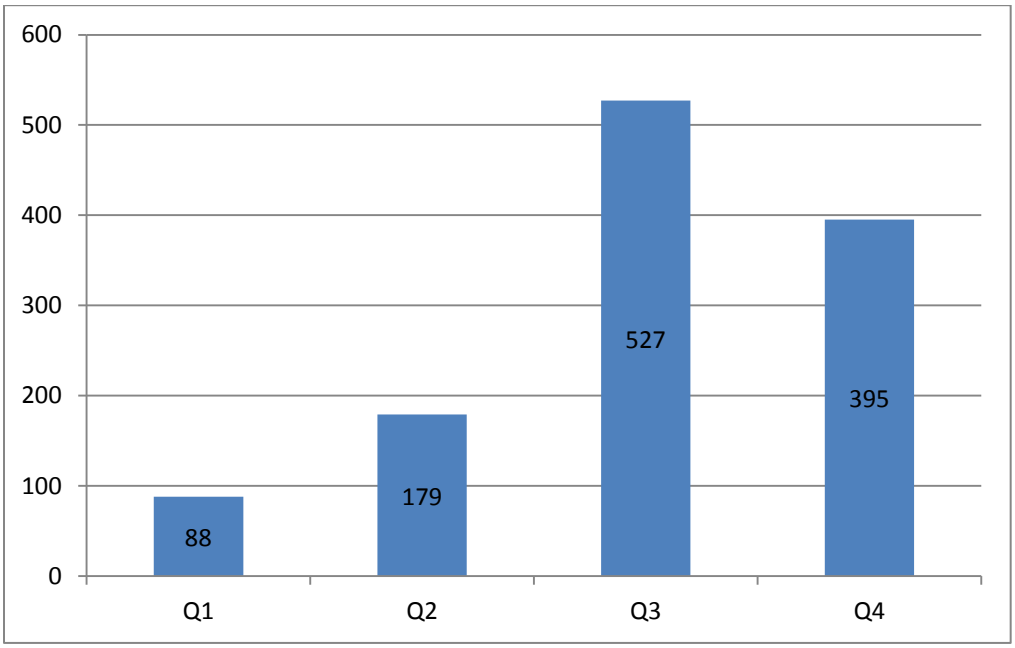
Accomplishments & Successes

This FY12 Q4 alone, 395 men (102 in Onandjokwe, 166 in Andara, 65 in Nyangana, 16 in Rehoboth and 42 in Oshikuku and 4 in Odibo) were circumcised. By the end of FY 12, a total of 1101 men (247 in Onandjokwe, 368 in Andara, 233 in Nyangana, 22 in Rehoboth, 227 in Oshikuku, 4 in Odibo) were circumcised. Figure 3 below shows the trends of MC from Q1 through Q4 of FY12. Consistent with the minimum package described above, most clients were tested for HIV; three (1.6%) clients of which 1 from Nyangana and 2 from Onandjokwe tested HIV positive. For FY12 Q4, two moderate adverse events (bleeding) were reported by Oshikuku and Andara. By the end of FY12, 6 adverse events (bleeding) were reported of which 5 from Oshikuku and 1 from Andara and one severe adverse event from Oshikuku; all

patients with an adverse event were attended to immediately. A total of 1, 662 men have been circumcised in the IntraHealth-supported sites since the inception of the program in 2010.

Currently five IntraHealth-supported facilities are trained in VMMC and one had onsite orientation by IH (Odibo) and providing VMMC services. IntraHealth also continued to actively participate in national VMMC training and quality assurance (QA) visits in collaboration with I-TECH and the MoHSS. IntraHealth staff (Dr. Alexis Ntumba) also performs MC at Windhoek Central Hospital at least twice per month. During FY12 Q4, he performed 9 MCs at WCH on three visits. The reduced number of visits was due to competing priorities.

Figure 3: Number of men circumcised



Other achievements during the reporting period include:

- Served as an active member of the MC task force.
- IntraHealth contacted the Ondangwa Prison and managed to get permission for prisoners to be circumcised once per week at Onandjokwe hospital.
- VMMC mobilization sessions conducted by Onandjokwe for clients seeking treatment and/or other hospital services as well as for some schools and workplaces.
- Organizing school campaigns in Andara hospital continued.
- Procurement of switch diathermy pencils for Surtron machines.
- Onsite orientation conducted on the use of diathermy machines at Onandjokwe and Nyangana
- Onandjokwe is recording referrals from HCT to MC
- Onandjokwe involved community leaders in the MC community mobilization in order for them the get the insight and thus address cultural barriers.

Challenges, Constraints and Plans to Overcome Them

Turnover of staff trained in VMMC is a challenge we are facing in assuring availability of services. Specifically:

- The Odibo medical officer trained in VMMC resigned leaving no staff trained in VMMC. IntraHealth will prioritize including Odibo staff in the next MC training and will strive to train at least two staff if possible to alleviate this situation in the future.
- There is low MC uptake in Odibo in spite of onsite orientation. Efforts using PIA are in process for improved MC uptake.
- The trained nurse in Rehoboth also resigned leaving the facility without a trained VMMC Service provider.
- The MC trainer at I-TECH resigned leading to postponement of MC trainings. IntraHealth will therefore organize onsite orientation for doctors and nurses while waiting for the I-TECH trainings.
- The onsite MC orientation for clinicians could not materialize due to mainly unavailability of clients for orientation and competing priorities.

Plans for Quarter 1 FY13

- Continue employing PI approach to further strengthen referral of clients from HCT services to VMMC. A register for referred clients from HCT will be encouraged to track referrals.
- Continue strengthening community mobilization around MC and involve community leaders to address cultural barriers.
- Continue to perform VMMC at Windhoek Central Hospital at least two days per month.
- Continue active support and facilitation of training in collaboration with I-TECH and MoHSS.
- Continue active participation in the MC task force.
- Procure MC kits (order placed and awaiting for the kits)
- On site orientation for clinicians from Rehoboth.
- Continue community mobilization with facilities, schools and workplaces in Onandjokwe district and all IntraHealth-supported sites providing VMMC.
- Continue encouraging the transferred nurse from Nyangana to Rehoboth to continue performing VMMC in his new work environment.
- Strengthen collaboration with private MC providers in order to provide their clients with counseling and testing in Onandjokwe.
- Support the payment of staff to perform MC during upcoming campaigns

2.3 Program Area 3: Post Exposure Prophylaxis (PEP)

According to Namibia's national guidelines, post exposure prophylaxis (PEP) must be provided within 72 hours following occupational, non-occupational or sexual exposure. IntraHealth continues to work towards strengthening the implementation of PEP guidelines, with a focus on data collection and reporting systems, while supporting training and skills updates, in order to improve awareness and eliminate missed opportunities for PEP within Namibian health facilities.

Accomplishments & Successes

All staff members working at IntraHealth-supported sites have been oriented in PEP, and all sites supported by IntraHealth have been provided with the standardized PEP register. During FY 12 Q4, 41 people were provided with PEP as follows: 6 due to occupational exposure, 13 from non-occupational exposure, and 22 rape survivors.

By the end of FY12, a total of 114 people (8 from Oshikuku, 67 from Onandjokwe, 8 from Odibo and 19 from Rehoboth, 4 from Andara and 4 from Nyangana), were provided with PEP. Of the 114 people, 21 were due to occupational exposure, 62 rape survivors, and 31 from non-occupational exposures. All PEP recipients tested negative initially. Follow-up of these clients at six weeks, three months and six months will be reported from the Quarter 1 FY13. Community mobilizers and prevention officers have also incorporated PEP information into their sessions in communities and workplaces respectively.

Other achievements during the reporting period

Two facilities (Rehoboth and Nyangana) used the PEP register provided by IntraHealth to capture the data. In Nyangana, out of 4 occupational exposures, all (100%) reported at six weeks, 3 (75%) at 3 months and two graduated negative after six months. Out of 4 rape survivors, none reported at six weeks, whilst for the non-occupational exposures, only 1 reported at six weeks and three months.

Challenges, Constraints and Plans to Overcome Them

- While reporting on PEP in general has improved at all the facilities, some occupational exposure clients do not complete the six months follow-up. In-service training will continue to be intensified for staff to improve awareness for clients as well as follow up.
- Most rape survivors are not returning based on the schedule of three follow-up visits over six months. IntraHealth will continue to work with the partners to ensure that awareness through counseling and community mobilizations is strengthened.
- Four facilities (Oshikuku, Andara, Odibo and Onandjokwe) did not use the PEP register to capture the date. IntraHealth will encourage these facilities to begin using the PEP registers to capture the data.

Plans for Quarter 1 FY13

- Continue strengthening awareness of PEP in the communities and workplaces by community mobilizers and prevention officers.
- Continue strengthening follow-up of PEP clients until discharged at six months.
- Strengthen reporting and testing of healthcare workers with occupational exposure, emphasizing confidentiality.
- Ensure that all IH supported sites are accurately using the PEP registers.

2.4 Program Area 4: Sexual and Other Behavioral Risk Prevention

A strategic priority for prevention according to the National Strategic Framework (NSF) is to reduce HIV incidence by 50% by 2015. This goal will be achieved by implementing interventions that reduce exposure to HIV, reduce the probability of transmission if exposure has occurred, and influence change in social norms, values and practices that prevent adoption of key prevention behaviors. Social behavior change communications (SBCC), positive health, dignity and prevention (PHDP) and reduction of gender based violence are the main interventions being implemented.

PHDP is a comprehensive program targeting PLHIV which incorporates: key behavioral prevention messages such as partner disclosure; counseling and testing and condom use; STI screening and treatment; FP for prevention of unintended pregnancies; alcohol assessment; TB screening, nutritional assessments, and medication adherence counseling. IntraHealth provides mentorship for its partners to implement PHDP and provides TA to the Society for Family Health (SFH) for its Most at Risk Populations (MARPs)/ Key Populations program.

IntraHealth's focus is now on ensuring sustainability of the prevention program through local ownership by mentoring partners to conduct effective support and supervision. IntraHealth has already begun transferring these skills to partners such as CHS. The PHDP program which was launched by training health workers during the first quarter. IntraHealth has from inception involved the MoHSS National Health Training Network, and will continue providing this training, mentorship and supervision for our partner staff.

Accomplishments & Successes

Positive Health, Dignity and Prevention:

In collaboration with the MoHSS/ NHTC and ITECH, during the first quarter IntraHealth conducted PHDP training for staff from CHS hospitals (Nyangana, Andara, Oshikuku, St. Mary's Rehoboth) and AMS St Mary's Odibo hospital. LMS Onandjokwe site was trained during the third quarter.

IntraHealth also collaborated with the MoHSS and the prevention stakeholders to develop PHDP performance support tools and reporting templates for both the nurses and community counselors. All six faith based facilities received orientation on the tools and staff provided feedback which will be incorporated in subsequent revisions. The tools have improved reporting on PHDP activities easier though there are still challenges with capturing and tracking those PLHIV receiving the complete package.

During FY12, a total of 13,832 PLHIV received the PHDP package in the IntraHealth supported sites.

Social Behavior Change Communication (SBCC):

The SBCC activities have declined in all the FBHs since the first quarter due to the scale down of SBCC and transitioning of this activity to local or community based organizations. The activity was finally transitioned out during the 4th quarter of FY12.

As part of the transition process, meetings were held with key stakeholders in the respective districts during the 4th quarter. The meetings were aimed at establishing the community based organizations

involved in PHDP and identify areas were there would be possible gaps once the prevention officers stopped providing these services. These key stakeholders included Catholic Aids Action (CAA), Nawalife Trust (NLT), and Society for Family Health (SFH) and LifeLine ChildLine (LLCL) and networks of PLHIV. In most of the districts, the upcoming Prevention Alliance of Namibia (PAN), a consortium of CAA, SFH, Nawalife Trust and Positive Vibes, will cover the SBCC, though it will be focused on PLHIV, forming the community PHDP piece. Therefore, gaps will still exist with respect to provision of SBCC in the community at large. The prevention officers' activities have now been shifted from SBCC to the hospital based activities such as PHDP and PITC.

Gender:

During FY12, 2,060 people (1089 females and 971 males) were reached through small group sessions. The 'Headman Forum' especially in Onandjokwe was influential in motivating community members to attend sessions targeting reduction of gender based violence. Communities look forward to these open and non-threatening dialogues in groups as relief for pent up emotions regarding gender based violence. During the sessions it was clear that gender base violence remains a big concern. Most people seem not to understand about the regulations and policies that the government has put in place. They realize the importance of passing knowledge to their community who would become knowledgeable of their rights, so that they can report any violation happening in their community. The participants reflected that alcohol, non-disclosure of HIV status, refusal by men to use condoms, poor and/or inadequate parental guidance are fueling violence within the community. Therefore interventions to reduce gender based violence should target alcohol abuse and parenting skills. Furthermore, participants have indicated that the discussions have helped to change attitudes and behaviors positively towards nonviolence and discussion as a means of solving disagreements within families.

The Dual Protection Tool:

Since the approval to pilot the dual protection tool was granted by the MoHSS' Permanent Secretary via PHC during the third quarter. The following sites have already been introduced to the tool and started testing it: St Benedicts Oshitutuma Clinic in Omusati region, St Mary's Odibo in Ohangwena region and Rehoboth Health center in the Hardap region, Tamariskia clinic in Erongo region, Divundu clinic in Andara district of Kavango, Robert Mugabe and Okuryangava clinics and Katutura health center in Khomas region. Divundu, Robert Mugabe and Okuryangava clinics and Katutura health center were oriented to the tool during the 4th quarter.

The orientation focused on building capacity of FP providers to;

- Start conversations with clients on HIV prevention as well as unwanted pregnancy prevention
- Deliver an effective brief motivational intervention that prompts clients to think about HIV prevention
- Empower clients to make healthy and informed choices to achieve their own goals
- Assist clients to set smart goals for HIV prevention using the Dual Protection Card Goal, which assists clients to identify current behavior and broader values and goals.
- Have confidence in their ability to talk to clients/community effectively about HIV prevention along with the drivers of the HIV epidemic in Namibia

Community Mobilization:

Most faith based facilities (except Rehoboth) conducted male conferences which aimed at increasing male involvement in the health of their families**.** The topics covered included HIV, male circumcision, gender norms and gender based violence, alcohol and alcohol abuse, parenting and family planning. Facilitators were drawn from the MoHSS, Ministry of Gender and Child Welfare, Ministry of Safety and Security, the churches, LLCL, and CACOCs. Voluntary HIV counseling and testing was offered on site and males were also referred for voluntary medical male circumcision at the hospital. A total of 182 males attended the male conferences and 44 received HIV counseling and testing on site.

Technical Assistance for MARPs to Society for Family Health

Through the Prevention Advisor, IntraHealth has supported the MARPs program in SFH. Technical assistance was provided in identification of the Key Populations, work planning, coordination and provision of training on SBCC theory and practice. The TA also conducted training of trainers (TOT) on voluntary counseling and testing (VCT), sexual and reproductive health (SRH), and HIV prevention for key populations. Technical support was also provided to SFH regional offices on outreach activities including VCT at mining and fishing companies. A high coverage of key populations with a core set of interventions aimed at targeted distribution of prevention products (condoms, female condoms, lubricants), evidence-based communication interventions designed to change risky behaviors (peer education, outreach sessions, trainings and assisting treatment implementing partners in setting up clinics were initiated with strengthening of referrals to MARPs-friendly services (STI diagnosis and treatment, HIV counseling and testing, PMTCT, ARVs, family planning, legal aid, psycho-social support with the component of income generation, still to be realized amongst organized MARPs groups).Performance support was also rendered to SFH staff and MARPs partners. Progress to date includes successful Regional Consultations, development of Work Plan, establishment of implementation modalities with partners, whom the MOHSS is a major who remains the custodian as far as linkages with HIV/AIDS National Strategic Framework (2010/11 – 2015/16) are concerned. The participatory development of program tools with the MARPs as designers and contributors, training of program partners on programmatic related issues, such as the SBCC Strategy, Mapping tools and the assessment of sub-awardees and identification of additional partners. The main outcomes; that more sex workers (SW) use condoms and lubricants, more clients of SW use condoms and lubricants , more men who have sex with men (MSM) use condoms and lubricants when having sex with a male partner, more MARPs have correct prevention knowledge has begun to be realized and scale up in efforts continues. The main challenge has been the slow progress in finding sizeable numbers of MSM as the 'snow ball effect' continues to gather more MSM at a slow rate. Through the MSM who have been able to come out, more will be able to come through and benefit from the program.

Challenges, Constraints and Plans to Overcome Them

- Transitioning out of prevention officers from SBCC activities in those districts where there are no CBOs delivering SBCC will leave a gap in the community at large.
- The PHDP FP component may not be realized at CHS within the envisaged 'one stop shop context,' due to CHS's policies against provision of FP services in their facilities. Patients will be referred to a nearby government clinic where appropriate or PHC departments within the district hospitals.

- Staff shortages and staff resignations have been hampering progress with full implementation of PHDP. Strengthening of PHDP activities will be done through mentorship and supervision in FY13. More staff in all sites still requires training in IMAI and PHDP due to attrition and job transitions. The PHDP trained staff are being absorbed in other departments where they are unable to relieve the shortage in the ART site consistently.
- Work overload at clinics have been a challenge with respect to recruiting clients for the dual protection tool. Some facilities are struggling to achieve the required sample for follow up. These include Odibo.
- Community mobilizations for MC have since been stopped during the fourth quarter due to the "yellow line" rating on MC for Namibia which does not allow expenditures on MC activities except payment of salaries and providing MC services.

Plans for Quarter 1 FY13

- Finalize the pilot of the dual protection tool and conduct the assessments.
- Strengthen PHDP reporting through refinement of the tool with the MoHSS and other stakeholders involved in PHDP.

2.5. Program Area 5: Counseling and Testing

The IntraHealth supported HCT program continues to run successfully and has experienced success in scaling up outreach counseling and testing services in conjunction with the MoHSS. IntraHealth continued to provide counseling and testing quality assurance. Beginning of quarter four the focus was on mentoring partner staff including Site Managers and Senior Counselors to ensure sustainability of quality HCT services beyond IntraHealth's involvement. During the fourth quarter IntraHealth began transitioning this mentorship role to the MoHSS's Regional Management Teams in the regions where IH supported sites are operating, namely, Hardap, Kavango, Oshikoto, Ohangwena and Omusati.

During the fourth quarter of FY12, 6,362 individuals received counseling and testing services and received their HIV test results. Of those who received counseling and testing in the fourth quarter 5,811 (91 %) were first time testers. Of them, 876 (15.1%) of the clients were tested as couples. During this quarter, 541 (9.3%) of first time testers were HIV positive. Among clients that were counseled and tested, 551 (8.7%) were repeat testers.

A total number of 28,064 clients were counseled and tested from October 2011 –September 2012. Among those, 26,801 (96%) were first time testers, with 15,325(57%) being females and 11, 476 (43%) males. 3,781 (14%) individuals were tested as couples and 2,152 (8.0%) individuals tested HIV positive (Figure 4 below).

Figure 4: Individuals and couples receiving HIV Counseling and Testing, October 1, 2011- September 30, 2012

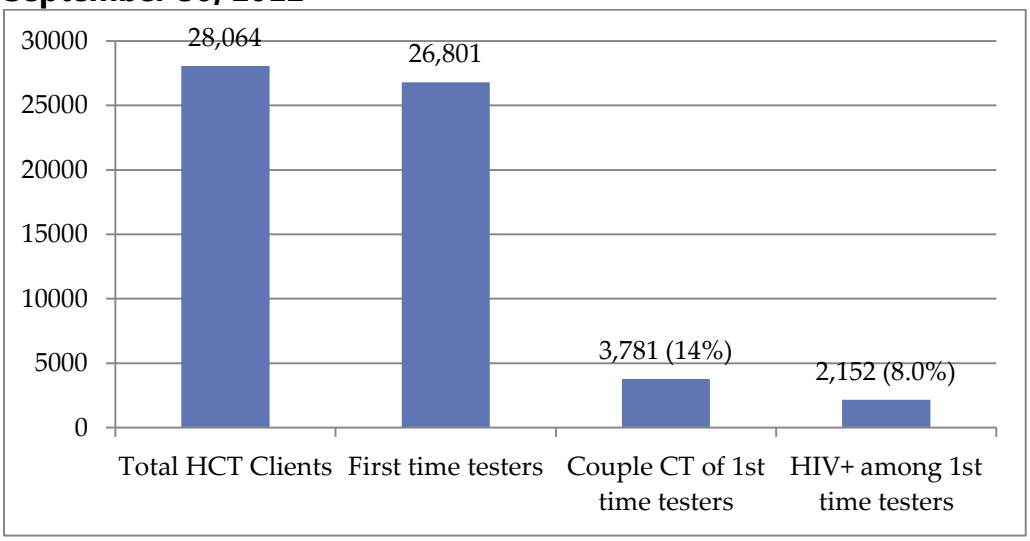


Figure 5: Individuals (First Time Testers) Receiving HIV Counseling and Testing, October 1, 2011- September 30, 2012

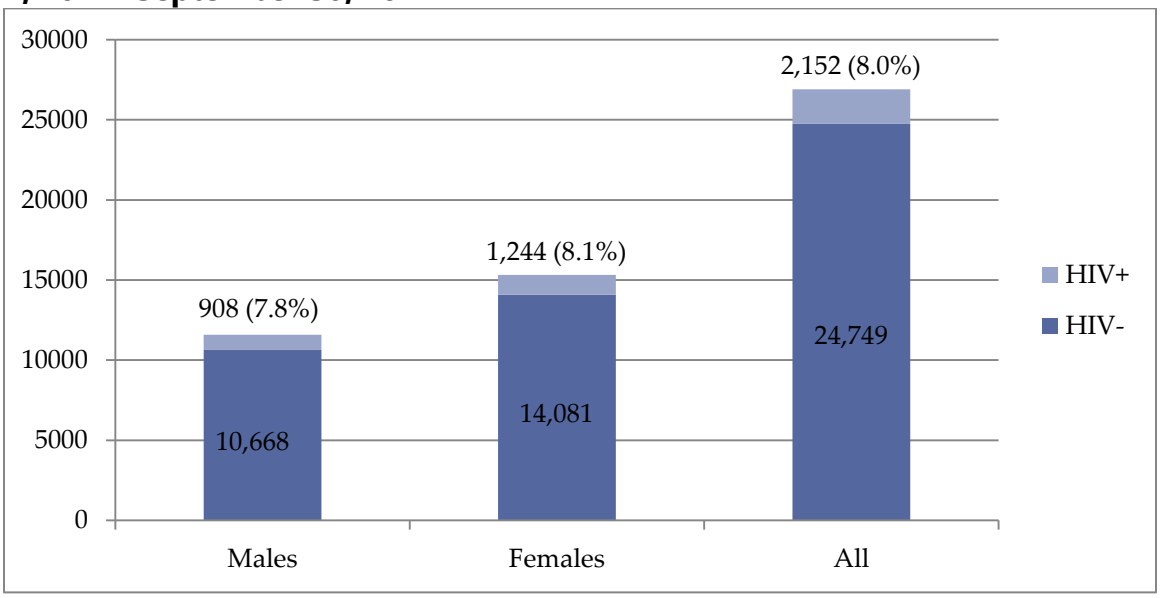
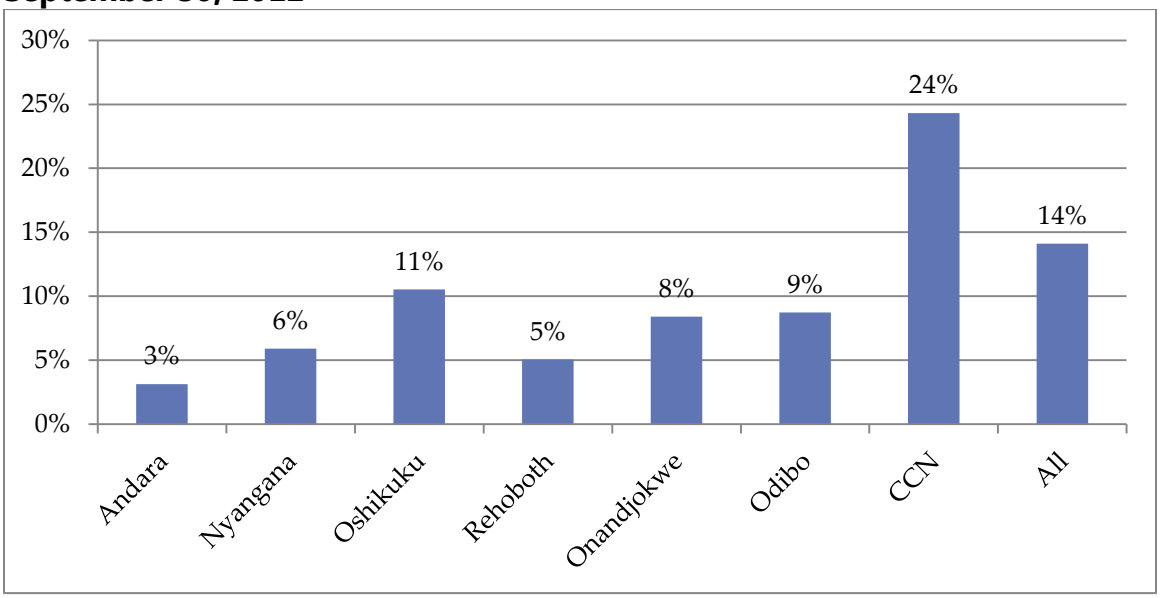


Figure 6: Percentage of Individuals counseled as couples by site during October 1, 2011-September 30, 2012



Accomplishments & Succeess:

- The three HCT Mobile vans procured earlier this year were finally delivered, branded and await handover to the MoHSS.
- Certification of 3 RT outreach points in Oshikuku facilitated by cultivating good partnership with Regional Management Teams (RMTs) and the Namibia Institute of Pathology (NIP).
- High male testing rates in CCN and Rehoboth (51% and 48% respectively) following advocacy programs through different media. This compares to an average of 43% across all the IntraHealth supported HCT sites.
- Joint supportive supervision visits to the regions with RMT and partners program staff successfully conducted.
- PIA training conducted to the IH partner staff and action plans drawn with the staff using the PIA.
- CCN successfully participated in piloting of the MOHSS M&E tools.
- Standalone New Start Centers received orientation from the regional teams on how to order their HIV Rapid Tests (RT) kits for October 2012 from the Central/ Regional Medical Stores. This change is a result of the transitioning of procurement of RT kits from MSH/SCMS to Central Medical Stores.
- Phase one of the HCT data analyses for the five standalone completed, awaiting dissemination to the stakeholders.
- Mentoring and Quality Assurance and supervision support visits were conducted to all IntraHealth supported sites and support supervisory visit tool used with the MoHSS RMT in preparation for the adoption of QA role to formerly IH supported sites.
- IntraHealth continued providing technical support to Lifeline Childline's CBD New Start Center to meet its QA requirements.
- Meeting held with LLCL, CAA, CCN and USAID to officially inform them of closing down of the remaining five standalone New Start Centers. This follows the directive from the Permanent

Secretary of the MoHSS to close them. Subsequent meetings with MoHSS and other stakeholders are planned during the next quarter.
- Final evaluation of Bi-directional Referral System conducted and draft report submitted to the MOHSS for finalization.

Challenges and constraints and plans to overcome them

- **Limited office space in most facilities.** The arrival of prefabricated structures at most of these sites expected to alleviate the space constraints.
- **Lack of Transport**: Remains a key challenge for most facilities thus negatively impacting on their ability to conduct outreach activities. Outreaches to other points suspended and service only offered at site were ART services are conducted so that the available car only to be used once a time for all. IntraHealth will donate a single cab 2.7 Toyota bakkie, and this will alleviate these challenges in Oshikuku district.
- **Low male and couple testing rates**: Facilities to map out plans for HCT staff to conduct special promotional events targeting males and couples and to establish friendly and accommodative environment.
- **Slow Integration HCT program Staff**: The HCT counselors at the integrated sites are anxious as absorption has so far focused on nurses, pharmacy staff and doctors. The transitioning or absorption of counselors from integrated sites is planned to be carried out in FY13. Appropriate communication will be sent to the respective partners to inform their staff in general and the counselors in particular.
- **Slow pace of HCT QA transition:** Although the MoHSS has written a letter to IH that the HCT Quality assurance training to CHPA/SHPA can be conducted, they have not yet provided the dates for the training. This has led to delays in the transition process. It is anticipated the training will now be conducted during the first quarter of FY13.
- **PITC Implementation** has not picked up well as nurses, doctors and counselors are supposed to be trained first. The training has been delayed due to a lot of competing priorities in the districts during the fourth quarter of FY12. The training has now been scheduled for end of November 2012.

Plans for next quarter

- HCT refresher trainings scheduled to cater for both child counseling and PITC.
- Regular HCT partner meetings to ensure smooth close down process.
- HCT Quality Assurance (QA) training for CHPA /SHPA to take place in this first quarter in preparation for the QA role transition.
- Sites to conduct HCT outreach activities with the Primary Health Care (PHC) in the districts.
- Plans underway to conduct male testing and male circumcision day at various facilities, in order to increase the uptake of males.
- All bi-directional piloting sites to develop intensified plan linking males testing HIV negative to facilities for Male Circumcision to increase uptake for MC
- Complete branding of HIV Counseling and Testing Mobile Vans to be handed over to MoHSS/RMTs.

- Bi-directional Referral System to be rolled out to the region after the final assessment.
- Facilities to continue intensifying male and couples testing promotions

2.6. Program Area 6: TB/HIV (HIVTB)

IntraHealth has continued its support to activities for strengthening collaboration between IntraHealth supported sites and MoHSS TB clinics to achieve better integration of TB/HIV services and thus ensure that HIV patients benefit from TB screening and treatment as needed and TB patients benefit from HIV screening and follow-up. Currently, IntraHealth is supporting 28 outlets for integrated TB/HIV services.

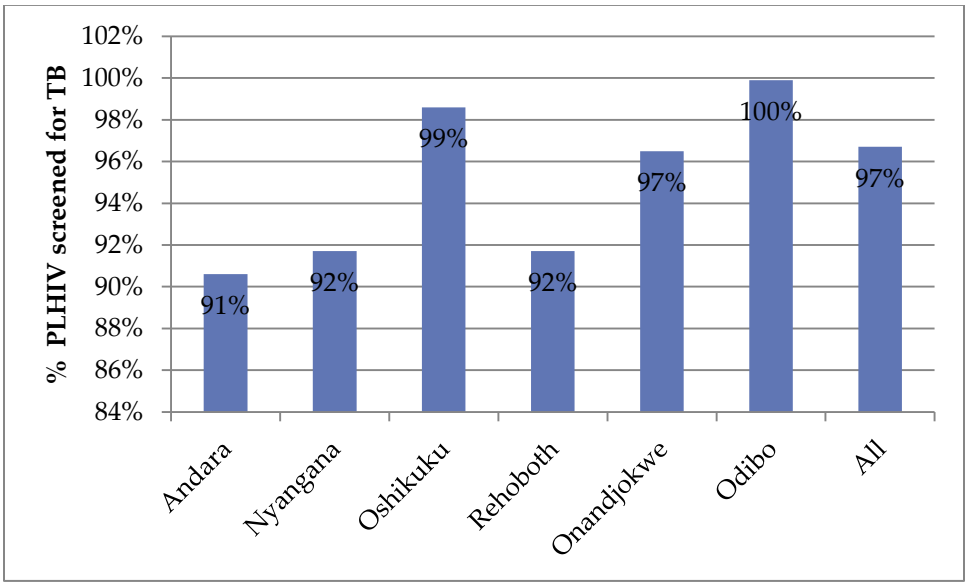
Accomplishments & Successes

To decrease TB among PLHIV, all sites are engaged in implementing the WHO-recommended Three I's: intensive case finding and early linkage to ART; infection control; and INH prophylaxis. To decrease the burden of HIV in TB patients, a successful collaboration and referral system between TB clinics and HIV services facilitates the routine offer of HCT to all TB patients presenting with unknown HIV status. Similarly, patients accessing services from other hospital departments, both IPD and OPD, are evaluated for TB when/if they are symptomatic and offered HCT using the provider-initiated testing and counseling (PITC) approach.

During the fourth quarter of FY12, a total of 254 (84.4%) of the 301 TB clients registered were tested for HIV and received their test results in the supported sites. Of those who were tested for HIV, 124 (48.8%) tested HIV positive. All TB patients testing HIV positive were referred for enrollment in HIV treatment and for clinical and laboratory evaluation, according to national eligibility guidelines.

By the end of FY12, a total of 1192 (85.9%) of 1388 TB patients were tested for HIV and received their test results with 612 (51.3%) testing HIV positive

Figure 7: Percentage of HIV Patients Screened for TB at last visit by facility, July – September 2012



All sites are synchronizing clinic visits for those co-treated to receive their follow-up care on the same day and reduce additional visits for each condition.

During the fourth quarter, 19,124 (96.7%) out of 19,773 patients enrolled in HIV care and who visited the facility during the reporting period were actively screened for TB at their last visit. *Figure 7* shows the percentage of HIV positive patients screened for TB during the fourth quarter of FY12, by facility. Of all the PLHIV screened for TB during this quarter, 65 (0.3%) patients were initiated on TB treatment. A total of 630 PLHIV were initiated IPT at the main IntraHealth-supported sites during this quarter. This brings to a total of 306 patients initiated on TB treatment and 3,044 on IPT during FY12.

Some other accomplishments during the reporting period included:

- Task-shifting of TB screening among PLHIV, from medical officers to registered nurses, is being implemented in all FBHs. The percentage of PLHIV screened for TB at each visit remains over 95%.
- Administrative measures to improve infection control continued to be enforced in most hospitals especially moving waiting clients into well ventilated waiting areas for example in Onandjokwe, Odibo, Andara and Nyangana
- All five FBHs have an isolation room/s for MDR- and XDR-TB patients.
- Rehoboth continued with the multi-disciplinary ward rounds on a weekly basis. These continue to provide a platform for better coordination of care for PLHIV. The team includes the medical officer, District TB Coordinator, ART Site Manager, Nurses, Counselors and a Social Worker. In the other sites, such coordination is enhanced through monthly TB/HIV collaborative meetings.
- Triaging of coughing patients is being implemented in Andara, Nyangana, Oshikuku and Onandjokwe.

- Prefabricated structures procured for almost all the FBHs should ease the space challenges experienced in the past

Challenges, Constraints and Plans to Overcome Them

- Staff movement, particularly medical officers' and nurses' resignations in Oshikuku and Rehoboth, continues to put a strain on the remaining doctors which may result in some TB/HIV activities such as screening TB patients at each visit and provision of IPT being compromised. The new nurses coming to work in the HIV program will need mentoring and training, particularly in IMAI to facilitate appropriate care of patients.

Plans for Quarter 1 FY13

- This activity will no longer be funded through IntraHealth but it is expected that TB/HIV activities should continue at the facilities.

2.7. Program Area 7: Care – Adults

To reduce morbidity and mortality among PLHIV, IntraHealth is supporting the facility-based clinical component of the minimum package of basic health care in six faith-based health facilities and their satellites. By the end of FY2012, 28 service outlets were providing the integrated palliative care package.

The following elements of the clinical care are provided: prevention and treatment of OIs, including co-trimoxazole prophylaxis for eligible HIV-positive patients; TB screening; Isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support (including spiritual counseling) and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Adolescent and Adult illness (IMAI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

- By the end of FY12, a total of 31, 777 eligible adults were provided with a minimum of one health care service. This represents 88% of 36, 149 of all adults and children receiving a minimum of one care service in all IntraHealth supported sites. A total of 25, 026 HIV-positive adults are receiving co-trimoxazole prophylaxis, representing 87.8% of 28, 498 of all adults and children on co-trimoxazole prophylaxis.
- Odibo has introduced Nutritional Assessment Counseling and Support (NACS), through which mothers and other patients are screened, treated and referred early and followed up. Also, patients are provided with basic knowledge on nutrition using cheap, locally available and nutritional foods. This FY12 Q4, 5 patients (2 children and 3 adults) have been identified and supplied with therapeutic and supplementary food. By the end of FY12, a total of 12 patients (4 children and 8 adults) have been identified and supplied with therapeutic and supplementary food.

- Five facilities (Andara, Rehoboth, Nyangana and Odibo, Onandjokwe) are now calculating the BMI. However Onandjokwe is still doing BMI on selected clients/patients with signs of weight loss, only one facility in Oshikuku does not calculate the BMI.
- Prefabricated structure for kitchen corner activities in Onandjokwe was delivered and officially handed over to the facility. This will encourage staff to re-start the kitchen corner activities.
- Performance Improvement Approach Trainings conducted in 3 regions for all IH supported sites. Facilities came up with action plans to closing the gaps identified.

Challenges, Constraints and Plans to Overcome Them

- Kitchen corner sessions were not conducted in Onandjokwe during this reporting period because of the dilapidated structure (tent) used for this activity. IntraHealth has procured a prefabricated structure for this activity.
- Kitchen corner in Oshikuku is not fully provided as the site does not have a functional stove for local food preparation demonstrations.
- The resignation of staff at the ART-Oshikuku had made the gaps identified (BMI not calculated) not being addressed. During our last supportive supervisory visit (September 2012), staff in ART were encouraged and oriented in BMI calculation.
- Kitchen corner utensils not yet procured for Onandjokwe and Oshikuku. IntraHealth receives the list of kitchen corner utensils from partners which are being processed.

Plans for Quarter 1 FY13

- Encourage Onandjokwe to re-start the kitchen corner activities.
- Procure kitchen corner utensils, stove for both Oshikuku and Onandjokwe.
- Continue to ensure that all IH supported facilities provide nutritional counseling and where possible refer for food support.

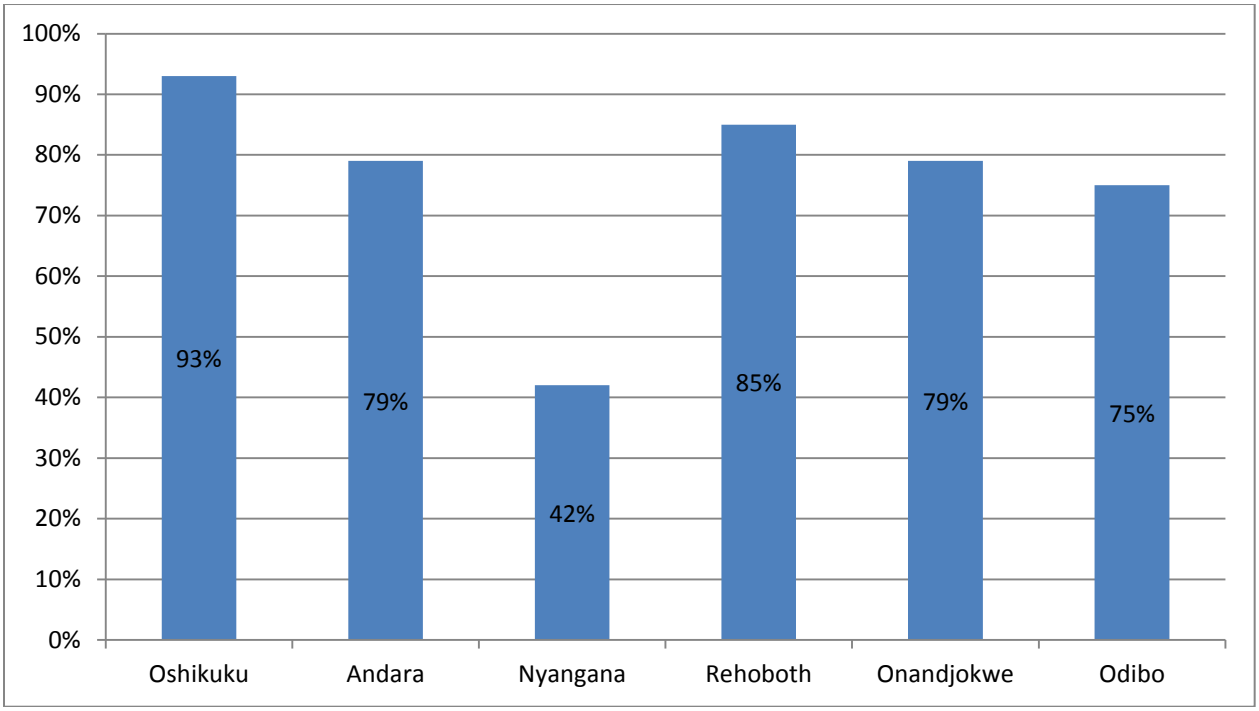
2.8. Program Area 8: Treatment: ARV Services – Adults

IntraHealth is supporting an integrated and comprehensive HIV and AIDS care and treatment program for adults in six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth supported 28 outlets in the provision of HIV and AIDS clinical care.

Accomplishments & Successes

Currently, 19, 543 adults living with HIV are receiving antiretroviral therapy (ART) at IntraHealth supported sites. By the end of FY12, 2, 661 adults living with HIV were newly initiated on ART.
During FY12 Q4, 579 adults PLHIV have been newly initiated on ART. Out of 305 patients started on ART on the Q4 of FY2011, 251 (82.3) are still alive and on treatment. We have also documented a relatively good trend of retention of ART patients (between 67% and 100%) as a result of significant and continued efforts in adherence counseling, support group activities and active defaulter tracing.

Figure 8: Retention in Care of ART Patients by Health Facility, July-September, 2012



- Medical Officers are now absorbed in to the Government system removing the previous gap in remuneration between staff paid by GRN and PEFPAR. All pharmacists in our IntraHealth supported facilities applied for absorption into the GRN system and were approved. They will begin to receive their salaries from GRN Quarter 1 FY13.
- The feedbacks of the ART SOPs from facilities were received; most facilities do not have any objection stating that all are from the Guidelines, which supposed to be the case.
- A joint supportive supervision visits with Regional management Teams conducted in all IH supported sites, except Onandjokwe (The RMT representative did not join the visit due to competing priorities).

Challenges, Constraints and Plans to Overcome Them

- The number of patients receiving services at ART clinics has outstripped the available space in most of the facilities. Increase in the outreach activities is also expected to decongest the main facilities. IntraHealth got approval to procure prefab units to all facilities to address the space challenge.
- All IntraHealth-supported sites are conducting tracing of ART patient defaulters; however, the availability and transport cost remain major challenges, especially in Onandjokwe. To bridge the gap, Onandjokwe is still conducting outreach services in 8 facilities of which 2 health center and six clinics.
- Nyangana recorded a very low retention in care (42%). This could be as a result data quality issues with some follow ups not entered into the database or just poor follow up. IntraHealth will work with CHS to identify the reasons for this and come up with appropriate interventions.
- All prefab units were delivered to the IH supported sites.

Plans for Quarter 1 FY13

- Continue providing care and treatment to all HIV-positive individuals in all IntraHealth supported sites.
- Conduct support and supervision to all the sites with the respective partner management staff with the aim of transferring supervision skills to them. Will support efforts to identify HIV/AIDS areas that can be integrated under the primary health care umbrella.
- Conduct a last joint support visit with the MoHSS Regional Management Team for smooth transition process.
- Compile the final draft for Treatment Standards Operating Procedures.

2.9. Program Area 9: Care – Children

IntraHealth is supporting the provision of care to children infected, or suspected to be infected, with HIV. The following elements of the clinical care are provided: prevention and treatment of OIs, including co-trimoxazole prophylaxis for HIV-exposed infants, TB screening; Isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support (including spiritual counseling) and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Childhood illness (IMCI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

As a result of the wide use of DNA PCR testing for HIV exposed infants, more infants and young children are enrolled in care. By the end of this reporting period, 4, 372 children under the age of 15 were provided with at least one HIV clinical care. This represents 12% of the 36, 149 individuals currently receiving care, including adults. A total of 3,472 HIV-positive children were provided with co-trimoxazole prophylaxis (CPT). This represents 12% of 28, 498 adults and children receiving co-trimoxazole prophylaxis.

In all IntraHealth-supported sites, pediatric care also includes the diagnosis and treatment of malaria, and referral for routine and timely immunization programs and campaigns. Routine provision of CPT at 6 weeks of age is given, according to the national guidelines for HIV exposed infants. For HIV+ children, CPT is continued, as well as IPT, TB screening, nutritional assessment, and pain management. All IntraHealth supported facilities offer diagnosis and management for OIs and co-morbidities, including diarrhea and pneumonia. As with adults, all children in care are screened routinely for TB in every follow up visit, and referrals are made for suspected cases to the TB clinic for registration, prescription and follow up. Likewise, HIV testing is conducted for all children diagnosed with TB. Infants initially testing HIV- but remaining at risk due to ongoing exposure from breastfeeding are also retested.

Additional highlights during FY12 include:

- Twenty seven children (21 in Odibo and 6 in Onandjokwe) received child counseling and disclosure using MoHSS and I-TECH tool.
- Twenty nine children between 6 and 18 have been registered and are going through the disclosure process
- A total of 562 attended pediatric-friendly services, which are housed in a special room and provided by specially trained nurses. These sessions assist children adhere to treatment and prepare them for the process of disclosure.
- In Onandjokwe, 381 children from the age of 7 have been registered for disclosure.
- The adolescent friendly services in Onandjokwe also provided support in the HIV disclosure process. By Q4 of FY12, 170 adolescents attended adolescent's friendly services making it a total of 980 adolescents attended adolescents-friendly services by the end of FY12, which included

sessions to respond to questions and concerns adolescents were able to provide anonymously in writing.
- NACS implemented in Odibo; all qualified clients/patients are provided with foods (Plumpy nuts and therapeutic fortified food)

Challenges, Constraints and Plans to Overcome Them

No kitchen corner sessions were conducted in Onandjokwe due to the problem of the dilapidated tent combined with heavy rains. Procurement of a prefabricated room to replace the tent is completed and officially handed over in Q4. This will reactivate KC activities in Onandjokwe hospital.

Plans for Quarter 1 FY13

- Conduct visits to all sites with partner supervisors to mentor them on support and supervision skills.
- Continue to employ the PI approach to strengthen NACS implementation and reporting.
- Encourage kitchen corner activities in Onandjokwe Quarter 1 FY13 since the prefab is installed.

2.10. Program Area 10: Treatment: ARV Services – Children

IntraHealth is supporting an integrated and comprehensive HIV and AIDS care and treatment program for children in all six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth supported 28 outlets in the provision of HIV and AIDS clinical care and ARV services for children.

Accomplishments & Successes

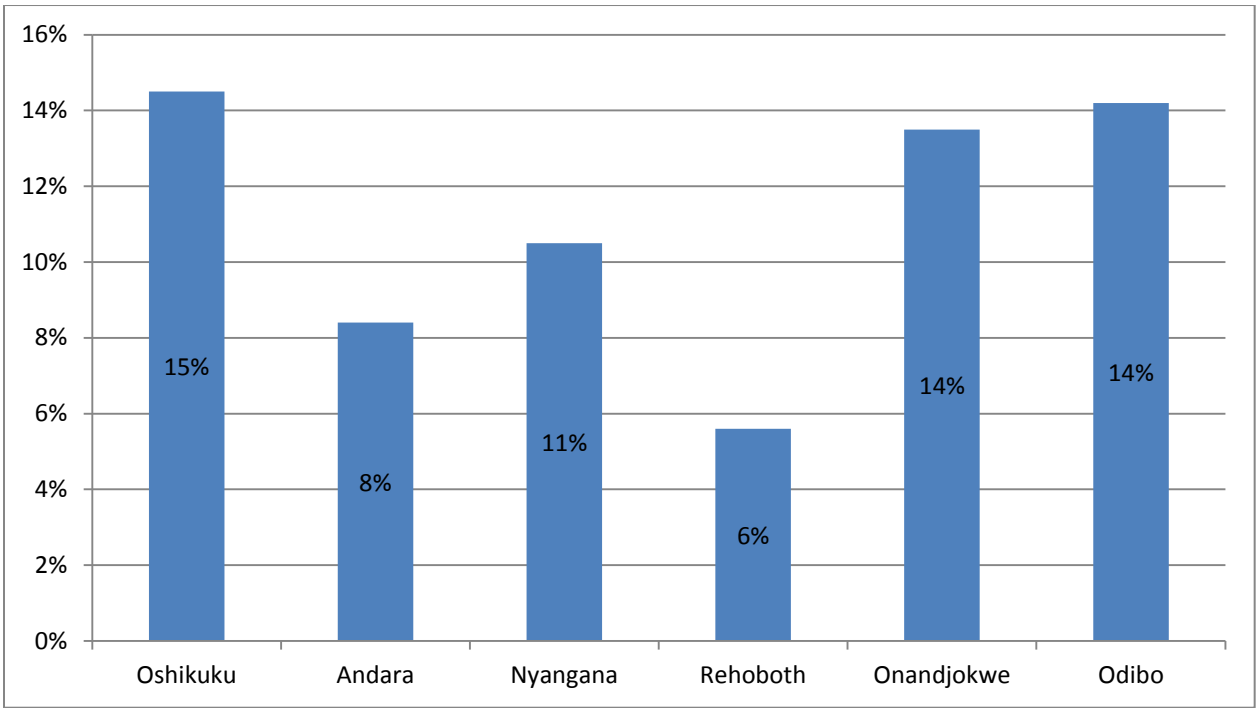
Overall, 2,798 children on HIV care are currently receiving antiretroviral therapy; this represents 12.5% of all patients. By the end of Q4 of FY2012, IntraHealth supported sites enrolled 63 children into ART. This represents 8.5% of adults and children enrolled into ART. By the end of FY12, 277 children were enrolled onto ART. *Figure 7* (see below) shows the percentage of children out of the total number of patients on ART, by facility, at the end of the reporting period.

Partner facilities have been continually sensitized to active screening and earlier identification and recruitment of HIV-exposed children in order to expedite entry into care and treatment. Early infant diagnosis and the recommended Namibian ART approach of commencing ART earlier for children have been rolled out in all IntraHealth supported sites. This change in treatment protocol is expected to have a significant increase in the ART initiation among children younger than 24 months of age. All identified HIV exposed infants will be provided with ARVs and cotrimoxazole prophylaxis as per the national guidelines.

The Onandjokwe and Nyangana clinics have continued with the pediatric ART clinics with Nyangana holding a quarterly event where all pediatric patients are booked to attend the ART clinic with their caregivers. Health education sessions for caregivers are scheduled during this event and they cover different topics including nutrition, disclosure and HIV prevention. All sites we support are implementing the new ART guidelines, which call for initiating ART with all children less than two years old regardless of CD4 count and clinical staging.

Five staff members were trained during last quarter on child disclosure (one nurse and two counselors from Odibo HC and two counselors from Andara. These trained staff will implement the HIV child disclosure in their respective facilities.

Figure 9: Percentage of ART Patients that are Children by Health Facility, October 2011-September 2012



Challenges, Constraints and Plans to Overcome Them

- Staff shortages in most facilities in Onandjokwe limit their ability to trace exposed infants at home. IntraHealth will continue to encourage partners to leverage the community based organizations such as CAA and Project Hope, to assist with follow up and tracing of defaulters.
- The majority of the ART nurses are not trained in the new guidelines; IntraHealth will continue to liaise with NHTC, RHTC and I-TECH to link to assist partners to develop and forward their training needs through relevant channels.

Plans for Quarter 1 FY13

- Continue strengthening defaulter tracing using SMSs, combination of trips with PHC team.
- Encourage in-service training in all IH supported sites on the ART guidelines

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2.11. Program Area 11: Health System Strengthening (HSS)

2.11.1 Human Resources for Health Capacity Building

The ability of IntraHealth's Namibian partners to operate as vibrant, autonomous organizations contributing to the national HIV response is a key indicator of project success. A critical step towards this indicator is empowering our local partners to directly access funding through a variety of sources including their own government, private and corporate sponsors and international donors and foundations. The initial goal was to prepare some of these organizations to eventually move to direct USAID funding (graduation). Two of our former partners are now receiving direct USAID funding – LifeLine ChildLine and CAA. However, with the recent program modification, the objective changed and IntraHealth is assisting our current faith-based organizations (FBOs) to transition their staff to non-USG funding and to improve their organizational sustainability and capacity.

Accomplishments & Successes

Conducting a Workload Indicator Staffing Needs Assessment (WISN) for the Kavango Region:
For over thirteen years, the Namibian staffing norms have not been revised although multiple positions have been added to the establishment to meet the workload requirements. The MoHSS is currently undergoing a restructuring effort to revise the staffing norms to meet the actual workload requirements. Kavango Region is one of the 13 regions in the country requesting technical support from IntraHealth to estimate their staffing requirements using workload estimates as part of this regional restructuring effort. The Workload Indicator of Staffing Needs or better known as WISN methodology was selected to determine the workload based staffing requirements.

Dr. Grace Namaganda and Nobert Mijumbi from IntraHealth Uganda provided the technical support based on their experience applying the WISN tool in Uganda. The staffing requirement for nurses, doctors, pharmacist and pharmacy assistants in intermediate hospitals, district hospitals, health centers, clinics and the Multi regional medical depot were determined. A total of 58 health facilities were included in the WISN for Kavango as illustrated below:

Level	**Number**
Intermediate hospitals	1
District hospitals	3
Health centers	7
Clinics	47
Total	**58**
Multi regional medical deport	1

The Kavango WISN results were presented to the Kavango Regional Management Team as well as to the MoHSS restructuring committee. Dr. Norbert Forster, Deputy Permanent Secretary of the MoHSS and also the Chairman of the restructuring committee, requested that the WISN should be conducted for the entire health sector. In addition, Dr. Forster requested Intrahealth to determine the workload estimates for the two main teaching hospitals in Namibia namely Windhoek Central Hospital and Katutura State Hospital. This request came as a result of a meeting of the Presidential Inquiry into the Activities, Affairs, Management, and Operations of the Ministry of Health and Social Services. In particular, a discussion regarding, "gaps in staffing capacity specialized doctors and registered nurses to provide practical training with the hospitals taking into account their current workload and the way forward including financial implications.

The technical team collected data on staffing levels i.e. determined the staff in post by category. All doctors were included in the current staffing levels for doctors. Nurses, pharmacists and pharmacy assistants supported by projects however were not included in the current staffing. Workload data were obtained from the HMIS, EPMS, PMIS, HRIMS and validated against patient records in the studied health units. Used data was for the period of 1st April 2011 to 31st March 2012, the Namibian fiscal year.

Staffing norms for intermediate hospital

Cadre	Current staff	WISN Requirement	Difference
Doctors	14	**47**	(33)
Nurses	152	**186**	(34)
Pharmacists	1	**4**	(3)
Pharmacy assistants	4	**10**	(6)

Staffing for district hospitals

Cadre	Current average	Min	Max	Average
Doctors	3	9	11	**10**
Nurses	39	38	54	**44**
Pharmacists	0	2	3	**2**
Pharmacy assistants	1	4	8	**6**

Staffing for District HC & Clinics

Health centers

Cadre	Current average	Min	Max	Average
Nurses	10	9	20	**12**
Pharmacy assistants	-	1	3	**2**

Clinics

Cadre	Current average	Min	Max	Average
Nurses	2	1	21	**4**

The region requires at least 77 doctors for the workload that the region experiences but there only 24 leaving a deficit of 53 doctors. Currently the few doctors in the region are working

under pressure with the highest pressure experienced by those in Nankudu and least in Nyangana. The shortage of doctors means that somehow their tasks are being shifted to other health cadres and in this particular case to nurses. This of has negative consequences on the quality of health care as well as the over burdening the nurses.

The region requires a total of 13 pharmacists but currently has only 2. None of the district districts has a pharmacist and yet they need 2 – 3 pharmacists each. All levels of health facility lack pharmacy assistants but particularly health centers. The lack of pharmacy assistants at the health centers result in task shifting to the already burdened nurses and further increases their work pressure.

Conclusions

- The staffing as determined by the WISN is the barest minimum for quality improvement
- Workload and hence staffing needs are likely to increase if the theaters in the district hospitals become functional
- The brunt of the current understaffing is being born by the nurses to whom most of the work is task shifted to
- There is need therefore to either officially accept this where by appropriate training and staffing for nursing will be mandatory

All levels of health facility lack pharmacy assistants but particularly health centers. The lack of pharmacy assistants at the health centers result in task shifting to the already burdened nurses.

Support to the Faith-based Organizations

Intrahealth hosted its second Partners' Meeting for 2012 early September at the Protea Hotel in Ondangwa. As the USAID-funded Capacity Building for Country Owned HIV/AIDS Services Project enters its final year, IntraHealth convened a meeting of its partners to review progress to date in HIV and MNCH services and discuss transition and integration issues as a precursor to the work planning session planned immediately after the Partners Meeting.

Namibia is one of three countries supported by USAID leading the way in transitioning from significant reliance on USAID funding for HIV/AIDS programs to self-reliance and sustainability. The process of transitioning USAID-funded staff to the Government of the Republic of Namibia (GRN) payroll has already begun, with doctors transitioned early in 2012. Pharmacists and nurses and possibly other staff such as data clerks are expected to transition in 2012. At the partner level, HIV programs, which until recently have been more or less vertically managed, are in the process of being absorbed into primary health care (PHC).The meeting was participatory in nature and included:

- Information sharing from and among partners, USAID and IntraHealth

- Presentations by partners, USAID and IntraHealth
- Review and discuss on of year 4 clinical services results
- Presentation and discussion of partner Integration Plans
- Skills building in areas relevant to the transition process in Namibia: Change management and leadership

Although IntraHealth had originally planned to engage an outside facilitator to manage the meeting, due to illness on the part of the consultant, the facilitation role was assumed by IntraHealth. As facilitation was shared among almost all IntraHealth staff attending the meeting, all IntraHealth participants were able to fully engage in the meeting discussions as well.

Catholic Health Services (CHS):
The Strategic Plan for CHS was finalized and presented by the Grow Consultants to the National Office Management Team. CHS is hosting its Annual Management Retreat in the Kavango Region at Sarasungu River from 5 to 9 November 2012 at which time the Strategic Plan will be shared with the rest of the regional managers. The strategic intent is the basis upon which the entire strategic agenda, strategy and roadmap is developed. Below is an outline of the building blocks of the organization's strategic intent for the next three years.

HIV Clinicians' Society (HCS):

The Strategic Plan for the HIV Clinicians' Society was finalized and presented at the Annual General Meeting. The Society's strategic intent is defined in its mission, vision and value statements.

Challenges, Constraints and Plans to Overcome Them

- The absorption process of pharmacists and pharmacy assistants is much slower than originally anticipated. Although the medical doctors transitioned over the MoHSS, the \ budget allocated to them by the MoHSS has not yet been increased. Therefore the FBOs still need to continue to pay for the salaries of these doctors from other funds since they no longer receive salary support from the program for doctors.
- Two main challenges resulting from the absorption of clinical staff include the lack of integration of HIV/AIDS under PHC umbrella and gaps in filled clinical positions offering HIV/AIDS services. In addition, since some of the services are being integrated under primary health care (PHC), some of these data are not being are not being captured by M&E. Since staffs are now being paid for by the GRN, they no longer feel indebted to track some of the data they previously tracked when they were paid by the program.

Plans for Next Quarter

The emphasis for next quarter will be to assist our partners to develop resource mobilization strategies aimed at ensuring organizational sustainability. Intrahealth will also provide support to LMS and AMS

to develop their strategic plans that will map out their plans for the next three to five years. The WISN work will continue and as already mentioned the MoHSS has expressed the need to conduct a WISN to inform the entire restructuring process which will scientifically show staffing requirements for both clinical and non-clinical cadres. It is envisioned that this process will take up to three years to complete.

2.12. Program Area 12: Strategic Information

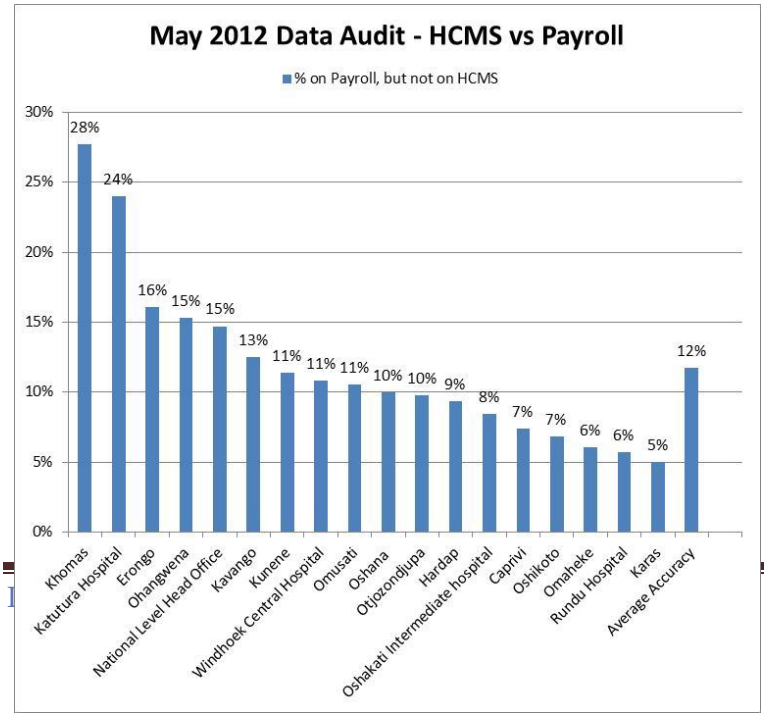
2.12.1 Human Resources Information System (HRIS)

The focus for the HRIS activities for the past year remained ensuring MoHSS has access to timely, accurate and reliable data on the status of Human Resources for Health (HRH) information as input to national level planning, policy- and decision-making. In previous years, IntraHealth worked with MoHSS to implement and rollout their Human Resources Information Management System (HRIMS) to all 13 regions in Namibia. In the second quarter, OPM started with the process to replace the HRIMS with an Oracle-based Human Capital Management System (HCMS) and IntraHealth continued to provide assistance to MoHSS to ensure the HRIMS data was migrated successfully and operationalizing HCMS within MoHSS.

CHS, LMS and AMS, the Health Professions Council of Namibia (HPCN) and the National Health Training Network (NHTN) were the stakeholders identified by the MoHSS, HRM Directorate with which they currently share data manually. Intrahealth engaged with them to provide TA in order to strengthen their systems and processes to ensure they have accurate and reliable data on registered health professionals in Namibia and pre-service trainees that can be shared with MoHSS to provide input to a national Human Resource Information System (HRIS). Currently the three FBOs and NHTN do not have an electronic HRIS and staff at FBO's is not considered public sector servants and are therefore not captured in the HRIMS or HCMS.

Accomplishments & Successes

HRIMS and HCMS: The Office of the Prime Minister (OPM) has replaced HRIMS with the Oracle-based Human Capital Management System (HCMS) and have migrated all the data from HRIMS to HCMS. IntraHealth provided support to verify the HCMS data against the payroll and HRIMS in order to verify whether the data was migrated successfully. Intrahealth supported this activity through employing two data capturers to do the data verifications and found that on average the HCMS data is only 12% inaccurate meaning 88% staff on the MoHSS payroll is captured on HCMS. We found that some data fields were not migrated and facilitated meetings between OPM and MoHSS to discuss the missing data and make recommendations. Through



this intervention, all date fields, including date of birth and salary numbers were subsequently correctly migrated. Intrahealth assisted MoHSS to develop a training plan and budget for the rollout and implementation of the HCMS although MoHSS decided to put the HCMS rollout on hold until the network issues are successfully addressed. IntraHealth extended the contract for one of the data clerks to continue providing assistance in capturing new appointments and staff movements on HCMS to ensure the data does not fall too much behind with the halting of the HCMS rollout.

IntraHealth has continued to work with MoHSS and OPM on operationalizing HCMS. Some of the support includes reviewing the standard data lists in HCMS, recommending changes to meet the Public Sector's reporting requirements, updating the HR processes document to reflect how HR Practitioners will be using HCMS and documenting reports needed by MoHSS. OPM was very happy with this initiative and congratulated MoHSS for their commitment in using HCMS and have requested permission to circulate the Reporting Requirements and Standard Data Lists developed for use by the other ministries. OPM has also requested IntraHealth to facilitate a workshop to merge all the reporting requirements so that they can prioritize the development and implementation of HCMS reports.

Other HRIS activities: Intrahealth conducted an HRIS assessment for LMS and AMS and documented the findings and recommendations. The findings indicate a need to standardize and align job titles with that of the MoHSS to support aggregation of HRH data at a National Level. Both are using a payroll system that HR staff and management are not able to access to retrieve basic reports. There is inadequate IT infrastructure to support a system that can be accessed by all HR staff and management. IntraHealth recommended customizing iHRIS Manage for the local context and to procure and implement computers and a Local Area Network (LAN) to strengthen the partners' IT infrastructure. This will support the implementation of iHRIS manage while ensuring all HR staff and management can access the system to retrieve HR data. IntraHealth appointed 4 IT Software Engineering Polytechnic students as interns, and facilitated their training in customizing the iHRIS Manage system for LMS. With the guidance of an iHRIS developer from Tanzania, promoting south to south collaboration, the interns completed the customization of iHRIS Manage for LMS and the user manual. Intrahealth scheduled implementation and training of the iHRIS Manage system for LMS in the second week in October. IntraHealth also subcontracted an IT vendor to install network points for all HR staff and management of LMS as well as supply and install 10 computers and 5 network printers.

IntraHealth met with representatives of the National Health Training Network (NHTN), a division in the HRM Directorate of MoHSS that provides pre-service training to assess their current systems and their ability to retrieve accurate and timely information on the number of students, the qualifications they are registered for and the forecasts of when they will complete their qualifications and be available for employment in the health sector. Intrahealth found that their processes are not supported by any database and that there is a need to automate the processes to:

- Manage their curricula,
- Register students, and
- Tracking students' progress through the courses they have registered for – including both practical and theoretical components on the courses.

IntraHealth interviewed some of the key users and IT consultant that provides support to the Health Professional Council of Namibia (HPCN), and found that although their system meets most of their daily

operational needs, they are not able to develop new reports in-house, is very dependent on the IT consultant to develop new reports, management does not access the system to run their own reports and there are some concerns on the accuracy of the statistics generated by the system. IntraHealth will continue to work with the HPCN to realize their key objectives which are too build internal capacity to improve the response time on IT support for their system, reduce their dependency on the IT consultant and to further promote the sharing of data with MoHSS.

Challenges, Constraints and Plans to Overcome Them

- HRH data for FBOs are not captured in HRIMS or HCMS, so MoHSS does not have access to detailed and up to date HRH information from FBOs. IntraHealth will implement iHRIS-Manage for the FBOs to give them a system to manage their HRH as well as provide MoHSS with access to accurate and up to date HRH data.
- MoHSS does not exchange data with the Health Professionals Councils of Namibia (HPCN) on a regular basis and in electronic format, leaving MoHSS unsure of the registration status of some of their clinical workers. IntraHealth has started to meet with HPCN to provide technical assistance to them to strengthen their system used for registrations of health professionals and will further work with them to develop a data sharing agreement between them and MoHSS.
- MoHSS is still experiencing slow response on their data network which has resulted in the HCMS rollout being put on hold. In addition MoHSS is planning to expand the Wide Area Network (WAN) to the district health offices which will further strain the WAN and is likely to decrease the response time again. IntraHealth recommended to MoHSS to replace the current MPLS-VPN, a shared network link between MoHSS and OPM, with a dedicated fiber connection.
- HCMS does not provide all the standard reports required by the MoHSS to use it for compiling their quarterly statistics and other HRH indicators. We have provided OPM with MoHSS reporting requirements and will continue to engage with OPM to ensure key reports are prioritized.
- A key risk to the success of the HRIS Program remains the MoHSS IT staff. The current level and capacity of the MoHSS IT staff is inadequate and HR system users are still experiencing delays in IT support. This matter has been brought to the attention of the MoHSS management, but informal feedback indicates that this will only be addressed as part of the Ministry's restructuring project.

Plans for Quarter 1 FY13

- Intrahealth will install the iHRIS Manage software for LMS and train HR staff in using the system to capture all new appointments, staff movements and qualifications.
- Conduct an HRIS assessment for all CHS facilities.
- Start customizing iHRIS Manage for AMS.
- Intrahealth will complete the assessment of HPCN's system and make recommendations to strengthen their internal capacity to support and maintain the system and share data with MoHSS and other HRH stakeholders.
- Complete the HRIS Assessment for NHTN to support the MoHSS to gain access to accurate information about student health professionals who are in the pipeline.

- Encourage the multi-sectorial stakeholder leadership group for human resources information to reconvene around next steps in developing an integrated HR information system as input to completing a draft design for a National HRIS.

2.12.2.1 Monitoring and Evaluation

FY12 has been a busy year focusing on reviewing the program's benchmarks, work plan, implementation plan, partners' indicator targets, data collection tools as well as strengthening the capacity of partners in strategic information as per current scope of work modification. IntraHealth has been also supporting MoHSS in the development of national electronic patients monitoring system (ePMS).

Supporting partners to improve the quality of data, data collection, data use and report writing has also been our priority. The goal is to effectively and efficiently monitor and evaluate the response of IntraHealth and its partners for informed decision making. This will strengthen the capacity of IntraHealth and its partners to collect and use program data and measure its achievements and provide for accountability to the donor. IntraHealth also supported its partners in the use of information for effective program management. This was accomplished through improving and harmonizing data collection tools, ensuring data coordination, data mining, analysis, dissemination and informing evidence-based program planning and improvement.

Accomplishments & Successes

Area	Activities
M&E documents review	✓ During the reporting period, the main focus was to develop relevant documents for IntraHealth; the M&E team has been working on developing the work plan and PMP, including reviewing and developing indicators as well as benchmarks.
M&E system for partners	✓ The M&E team has been strengthening the M&E system of partners by providing regular technical support, including working with the CHS, LMS and AMS teams on reporting requirements (indicators and indicator template plus narratives) consistent with USAID requirements. ✓ Partner staffs were provided with onsite training on narrative report and indicator template completion.

Capacity building to partners	✓ IntraHealth's M&E team provided technical assistance to CHS during the year following the resignation of their M&E officer in November 2011. The focus of this TA to CHS was around reporting requirements and indicator data for their all programs. ✓ IntraHealth also supported partner staff on ePMS, specifically how to clean data once reported from the health facilities, generate PEPFAR indicators, and to produce other care and treatment reports for program planning and evidence-based decision-making. ✓ LMS was provided with technical support to strengthen care and treatment reporting system and the improvement has been discovered. ✓ As part of strengthening the capacity of partners in strategic information, one- week training on Microsoft Word and Excel was successful provided to 23 partners' organization staff to improve their report writing skills. ✓ Another training conducted was on data quality management and verification whereby facilities developed their DQA plans for implementation.
Capacity building from CH	✓ IH CH MER Technical Advisor visited Namibia IH office and provided technical assistance to the staff on planned surveys, data quality issues and general M&E system strengthening work.
Integration study	✓ With support from IH CH office, M&E staff has finalized the protocol for the studies on Integration of HIV services and transition of HIV program staff.

2.12.2.2 Electronic Patient Monitoring system for ART

A sound patient monitoring system is the backbone of any HIV prevention and AIDS clinical care and treatment. An efficient HIV care system, including ART, requires the establishment and preparation of a clinical team that will be able to provide continuity of HIV care with a record that is capable of providing summaries of care and allow the health worker to understand what has happened in the life of the patient concerned.

IH has been supporting the MoHSS to developed and maintain an electronic version of the ART patient monitoring tools has been developed using the File Maker Pro platform to support and complement the paper based system. Having both paper-based and electronic systems in place will decrease the amount of data collected through the current ART system, ensure accurate and timely reporting, as well as to accelerate the integration of the IMAI strategy. The patient booklets have recently been updated to include separate booklets for adults as well as for pediatrics. With the above as background, it is clear that ePMS needs to be updated to serve the needs of the MoHSS. IH has recruited a Consultant to support the MoHSS in the day-to-day management of the database and mentoring of the MoHSS staff in the use of database and to make changes themselves to the code in the future.

Accomplishments & Successes

During Quarter 4, progress has been made on the following activities:

- The M&E staff at MoHSS (DSP) recommended using the latest version of Filemaker (12) because of the added benefits of ease of analysis and report development.

- RM&E has updated and shared the patient booklets for both pediatric and adult patients in separate booklets which will require changes in the current database.
- M&E is also expressing interest to create a National Database and requested IH to support this; this has been included in the TOR for the consultancy.
- The consultant started the work with the Intrahealth staff and the RM&E staff. The consultant started to make the necessary changes in the current system to include the new uptake forms for both the pediatric and adult patients.
- It is expected to finalize these updates, the creation of the national Database, training the staff, training interns for program modification during the first half of the coming fiscal year (July 2013).

2.12.2.3 Research

Accomplishments & Successes

Operations research is critical in providing scientific evidence for health and disease control programs to improve their quality and "learning" as they scale up. In the context of aligning international health support, the need to develop a framework endorsed and recognized by a wider professional community as a commonly-used instrument for designing, planning, implementing and taking full advantage of effective OR has been well recognized. To be effective, HIV/AIDS programs require not only community involvement and dedicated, committed personnel, but also detailed planning at all levels, close coordination of program implementation efforts, careful training and supervision of personnel, and continuous evaluation of program development and impact. Operations research is a critically important way to support and inform these essential planning, coordinating, training, and evaluation functions.

Despite the current best efforts, there is a lack of trained staff and training facilities in operations research in Namibia. It is widely believed that the utilization of OR depends upon increasing local capacity to conduct OR and to present the findings which could be easily utilized by program managers for programmatic decision-making. This means increasing the consumer base of organizations that demand information generated through operations research and increasing the number and quality of staff and organizations capable of producing quality operations research. IntraHealth capacity building strategy emphasizes collaboration with other organizations that can provide stable environments for training in applied research. Priority is given to activities with regional centers or institutions serving important, large-scale reproductive health programs and working in close collaboration with the Ministry of Health and Social Services (MoHSS).

Accomplishments

- Meetings were conducted with the UNAM health faculty staff and staff from the Management Information and Research subdivision in the MoHSS to discuss support for operational research projects and training on operational research.
- In the last quarter of the year, IntraHealth has successfully conducted Operation Research training for the partners as part of the capacity building to;
- Understand what research is and the contribution it can make towards solving priority problems in health care within the local context.

- Designing the health system research proposal
- Implement the proposals in their own working situation and share the results

With technical support from UNAM, Intrahealth hosted and organised a 3 week workshop on OR in Oshakati. This was , from 10 - 28 September 2012. There were 21 participants at the workshop, representing 5 health facilities and MoHSS (Central and RMT).

The workshop methodology combined a number of presentations followed by extensive group work which included case studies, role plays and interactive discussion sessions. By providing a firm grounding in such a topic as Operations Research, the workshop had three sections below:

Section 1: Introduction to Operations Research and research proposal development
Section 2: Introduction to statistic and analytical epidemiology
Section 3: Statistical software: EPI INFO

Based on the guidance from the training the participants tried to identify researchable problems in their own context, discussed on it and developed draft of their research proposals. The analysis capacity of participants was built from the section 2 and the use of statistical software particularly Epi Info were acquired by all the participants.

The four groups developed the proposals on the topics below:

1. Factors determining the morbidity and mortality due to TB in Andara District, Kavango Region
2. Strategies for improving low male engagement in sexual and reproductive health in Nyangana District, Kavango Region
3. Assessment of low uptake of male circumcision at Onandjokwe Hospital and Odibo Health Center
4. Strategies for improving poor utilisation of PMTCT services at Oshikuku District?

Challenges, Constraints and Plans to Overcome Them

- Since some program staffs are integrating onto the government payroll, M&E activities remain a challenge to the under-staffed partner organizations as they are overloaded with other day-to-day responsibilities.
- Reporting by field offices needs additional support from national office of partner organizations, which will help to improve the quality of data collected and will enhance ownership, involvement and commitment.
- Need to continuously strengthen research capacity and support the partner staff to finalize their proposals.

Plans for Quarter 1 FY2013

In the program's fifth and final year, the main focus will be to improve M&E skills and knowledge within partner organizations. Intrahealth will provide technical assistance in ePMS, data quality, report writing and data analysis. In this final and important transition year, the following activities will be executed:

- During the Quarter 1 FY13, IntraHealth will support technical training for the RM&E staff and interns and create the site level and national ePMS system and through training and mentorship, will support MoHSS to ensure adequate skills on ePMS for RM&E staff.
- IntraHealth will also support the MoHSS to develop the national database system and provide technical support to the RM&E staff.
- To strengthen partners' capacity in supportive supervision, IntraHealth will conduct M&E mentorship visits to partner offices, and continue holding quarterly M&E partner meetings for feedback and discussion of M&E issues.
- IntraHealth will continue to support CHS to strengthen their newly appointed M&E person.
- In collaboration with the MoHSS, IntraHealth will work with the HCT team to finalize the data collection tools and integrate the New Start HCT system into the MoHSS HCT system.
- Provide TA to partners to implement data quality and verification plans to ensure data accuracy and develop approaches to correct discrepancies.
- Mentoring and coaching to strengthen partners' monthly and quarterly report writing.
- Support partners to strengthen connectivity and reporting system (replacing old computers and procure switches for filemaker server etc.)
- Strengthen the newly established Data Quality Committees at facility level
- Continue discussing the integration of HIV M&E system into the facility M&E system

2.13 Issues with Data Quality

The IntraHealth M&E team provides partner organizations with coaching and mentoring on data collection and ensuring data quality, record-keeping, program reporting, HMIS systems, and other quality improvement initiatives. IntraHealth is implementing the quality in, quality out (QI/QO) model with all partners to ensure data gathered is valid, reliable, accurate, precise, and timely.

IntraHealth continues to provide technical assistance to improve data quality, including regular data quality checks to confirm appropriate data management systems are in place and verify the quality of reported data for key indicators at sites. On a routine basis, IntraHealth implements the following to assure that the data received from partners and report to USAID is of high quality:

- Monthly data reports are routinely verified and feedback is provided to the reporting sites.
- Mentoring and provision of technical support provided for partner organizations to ensure problems with data are adequately addressed.
- At the end of each month, discrepancies between the data entered in the electronic and the paper based systems are identified and addressed at the facility level.
- The IntraHealth M&E staff assists partner organizations to routinely verify data reported monthly, and provide feedback to the reporting sites.
- Quarterly data quality checks are conducted for program data.
- Data submitted to IntraHealth are checked by district coordinators and program managers at site level and program managers at national level before submission.
- The VCT & ART electronic systems have built-in data quality checks, which the data clerks and site managers confirming quality and consistency.
- Staff that handle data are supported by the senior management to ensure that problems are adequately addressed.
- Reporting period indicator templates submitted are checked and verified against monthly reports submitted.

Specific concerns with the quality of the data provided in this report:

- Late reporting of data is still a concern with some partners and this does not allow enough time for sufficient data verification prior to submission of our report to USAID by the 22nd of month after close of the quarter.
- Program staffs are being integrated into the government payroll and M&E activities remain a challenge to the under-staffed partner organizations as they are overloaded with other day-to-day responsibilities. M&E staff are concerned about their integration into the GRN payroll.

How Intrahealth is improving the quality of data:

Intrahealth continues to address concerns about and improve the quality of program data. IntraHealth and the partners continually identify ways to improve data collection, analysis and utilization:

1. During the last quarter, partner facilities established Data Quality and Verification Committees to strengthen data issues at their respective facilities. These committees consist of HIV program staff as well as the HIS officer and staff from DCC management.

2. M&E Capabilities, Roles and Responsibilities

- Support partner organization staff in routine M&E activities.
- Continued technical support to partner organizations.
- Quarterly meetings and feedback with M&E staff at partner organizations and focal person.

3. Training and support

- Train and support partners in monthly and quarterly report writing.
- Build capacity of partners to conduct trainings on data quality, verification and use.
- With partner organizations, provide mentorship and refresher trainings on the data collection tools and systems for each program.
- Support MoHSS to ensure health workers and data clerks are properly trained in the revised ART patient monitoring tools and ePMS in accordance with the new guidelines.

4. Data-collection and reporting

- In collaboration with the MoHSS and other partners, review and update monthly reporting tools and systems.
- Harmonize data collections tools with the MoHSS and other partners to ensure that all partners use standard data collection and reporting forms.
- Develop source documents for all tools and make them available to all partners.
- Strengthen the reporting system for the partners.
- In collaboration with M&E persons at partner organizations, develop clear documentation on data collection, aggregation and manipulation.
- During quarterly M&E meetings, identify data quality challenges and solutions for addressing them.
- In collaboration with M&E persons at partner organizations, develop procedures to identify, reconcile discrepancies in reports and verify source data.
- Through partner organization, provide feedback to the reporting sites on a monthly basis in order to motivate quality of data.

Links with National Reporting System

- Align partner and IntraHealth data collection and reporting systems with the national reporting system.
- Support the development of the national M&E system.
- Integrate partner reporting into the reporting process for the System for Program Monitoring (SPM) and continue strengthening the collaboration between the partners' organizations, the Regional Councils and the National M&E office.
- Continued discussion with the MoHSS and monitoring of the integration of services and transition of staff into the overall MoHSS system.

Environmental Issues

During FY2012, in compliance with USAID environmental requirements and regulations as per the 22 CFR 216 integrated into ADS 204.5, IntraHealth and the project-supported sites conducted the following:

- Triaging of coughing patients to minimize risk of exposure to TB and other infectious respiratory conditions.
- Patients and staff in MDR-TB wards have been provided with N95 masks.
- Counseling of TB patients is also done in the special rapid test (RT) rooms located in or near the TB wards.
- Use of open areas, such as verandas, as patients waiting areas, to improve infection control.
- Staffs are supervised to adhere to appropriate waste disposal, including sharps, medical waste (including foreskins from MC and placentas from deliveries) and condoms used for demonstrations in counseling and testing.
- Safety measures are observed while transporting waste generated from outreach services.
- All RT sites and testers were supervised by Site Managers and IntraHealth Regional Coordinators on a quarterly basis to ensure the correct techniques are used as well as adherence to safety regulations and proper disposal of waste and needles.
- Cleanliness and hygiene in all centers have continued to receive emphasis, and sites where food is prepared are made aware of the necessity of hand washing for both those who are cooking and for clients receiving food.
- Patients are continually provided with information on how to safely dispose items, and recycling bins are being maintained.
- IntraHealth also supported procurement and installation of prefabricated structures in the FBHs. Prior approvals were obtained from the respective church authorities and relevant certifications done in Onandjokwe where installations have been completed. In other sites, the certification for the prefab structure, slab, electrical wiring and plumbing will be obtained as required.
- Additionally, IntraHealth updated its Environmental Review Report (ERR) and Environmental Mitigation Management Plan (EMMP) to reflect some changes in the program such as inclusion of the Emergency Obstetric and Neonatal Care (EmONC).

End of Report